

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and certified to the funeral director, it should be delivered for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked off, show any injury, or other traumatic event, the medical examiner will be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8608561	
1 - STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR	
1 DECEASED NAME FIRST MIDDLE LAST			March 25, 1986							10:20 AM	
GEORGE ELEHUE ANDERSON											
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		
July 13, 1907		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		78 YRS		MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b CITIZEN OF WHAT COUNTRY? USA		8			9 BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.				
10 CITY OR TOWN OF DEATH Jarrettsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION IF NOT IN HOSPITAL, GIVE STREET ADDRESS 3853 Old Federal Hill Road		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter			12b KIND OF BUSINESS OR INDUSTRY Industrial				
13a STATE Maryland		13b COUNTY Harford		13c CITY OR TOWN Jarrettsville			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 21084 3853 Old Federal Hill Road		
14 FATHER'S NAME FIRST Frank		MIDDLE —		LAST Anderson			15 MOTHER'S MAIDEN NAME Minnie		LAST Cleary		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No		16b SOCIAL SECURITY NO. —		17 INFORMANT			17d ADDRESS Road, Jarrettsville, Md. 21084 Mrs. Zella M. Anderson, 3853 Old Federal Hill		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2wk		
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Ascites by Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Diabetes mellitus, Multi-Stroke Demenit, CVAs.											
19a MEDICAL CERTIFICATION DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 19 86		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (1) (this hospital) attended the deceased from saw the deceased alive on above, (1) (we) (did) (did not) view the body after death.										21 15, 19 81, to 21 25, 19 86, that (1) (we) lost	
22b SIGNATURE RANDALL C. CRONIN, JR., M.D.										22c. DEGREE	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Randall C. Cronin, Jr., M.D.										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b DATE Mar. 28, 1986	
23c NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gardens, Bel Air										23d LOCATION CITY OR TOWN Harford County STATE Md.	
24 FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009										25a. DATE REC'D. BY REGISTRAR MAR 31 1986	
										25b. REGISTRAR'S SIGNATURE	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 8 5 6 2

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Bessie</i>	MIDDLE <i>A.</i>	LAST <i>Baird</i>	20. DATE OF DEATH MONTH DAY YEAR <i>March 7, 1986</i>	MONTH DAY YEAR <i>81 YRS.</i>	2b. HOUR IF UNDER 24 HRS. <i>4 PM</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>June 6, 1904</i>	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR <i>81 YRS.</i>		7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE COUNTRY <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Hartford</i>		MD.	
10. CITY OR TOWN OF DEATH <i>Hartford, Conn.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Hartford Mem. Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>-----</i>		
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Cecil</i>		13c. CITY OR TOWN <i>Port Deposit</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>954 Jacob Tome Hwy. 21904</i>	
14. FATHER'S NAME FIRST <i>Richard</i>		MIDDLE <i>-----</i>	LAST <i>Blackson</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Ruth</i>		MIDDLE <i>-----</i>	LAST <i>LaMar</i>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? YES OR UNKNOWN <i>No</i>		16b. SOCIAL SECURITY NO. <i>218-54-0175</i>		17. INFORMANT <i>R. Rebecca Kyle</i>		ADDRESS <i>21904</i>		
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b) and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DUE TO, OR AS A CONSEQUENCE OF (b) <i>Asced</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteria + peptic ulcer</i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>3-7 86</i> to <i>3-7 86</i> , that (I) (we) lost saw the deceased alive on <i>3-7 86</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.								
22b. SIGNATURE <i>Jolene Yur</i>		22c. DEGREE <i>Jolene Yur</i>		22d. ATTENDING PHYSICIAN <i>Jolene Yur</i>	22e. MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22f. DATE SIGNED <i>3/2/86</i>		
22g. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Jolene Yur</i>		22h. ADDRESS <i>Hartford, Conn. Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>03/10/86</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Hopewell Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Port Deposit Cecil</i>	STATE <i>Md.</i>	25a. DATE REC'D. BY REGISTRAR <i>Lee A. Patterson Son</i>	25b. REGISTRAR'S SIGNATURE <i>Lee A. Patterson Son</i>
BP _____		Lee A. Patterson & Son Perryville, Md.		MAR 13 1986				
DHMH - 16 60M 7/B4 (VRA 15, 4)								

26 200-00



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

REPORTANT: If Item 21 is marked or Item 22 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

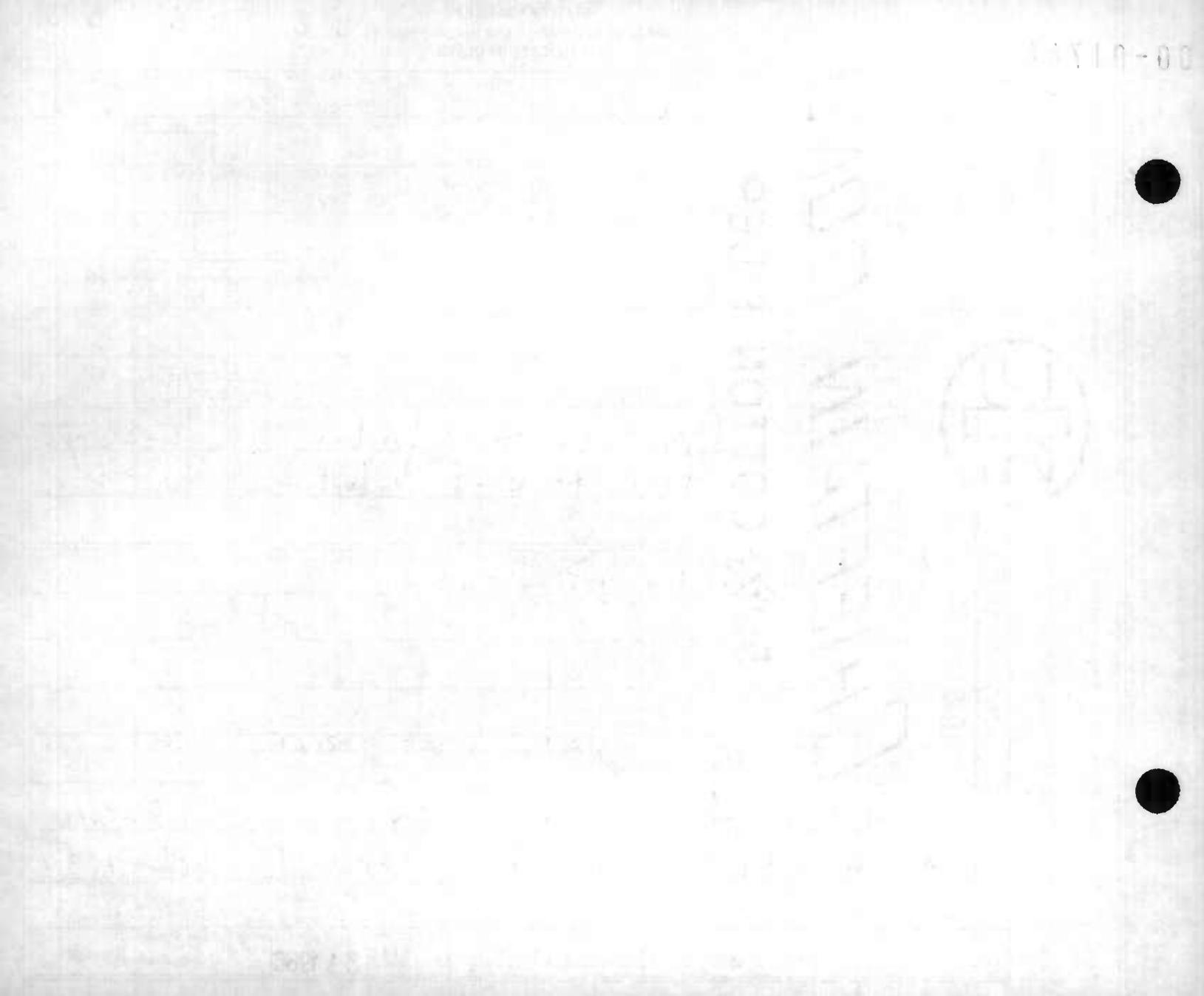
8608563

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
Birchel Paul Baker						March 27, 1986				1005 P.M.			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.						
Male	White	July 4, 1905			80								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.						Harford MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Abingdon		312 Amy Drive			Foreman			Painting					
13a. STATE Maryland						13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3545 Churchville Road/21001	
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST	Coale			
Charles			H.	Baker	Anna								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS				
NO			N/A			Marguerite Baker, 3545 Churchville Rd.,			Aberdeen, MD, 21001				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Digestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Lower Respiratory Infection</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>													
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 - 2 DAYS 2 - 3 days													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Senile Dementia & Parkinsonism</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
					YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/20</u> , 19 <u>86</u> , to <u>3/21</u> , 19 <u>86</u> . that (I) (we) last saw the deceased alive on <u>3/26</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Dudley Phillips Jr.</i>					DEGREE			DATE SIGNED <u>3/20/86</u>					
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dudley Phillips Jr.</i>		22d. ADDRESS <i>Box 3001 Arlington Md 20034</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 31, 1986			23c. NAME OF CEMETERY OR CREMATORIAL Baker Cemetery			23d. LOCATION CITY OR TOWN Aberdeen, Harford, Maryland					
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399					25a. DATE REC'D. BY REGISTRAR MAR 31 1986			25b. REGISTRAR'S SIGNATURE <i>Julie Swanson-Pender</i>					

14510-00



0-02264

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 08564

REG. NO.

1 -
STATE
REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
JOHN C BECK			3 20 86	43 PM
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
Male	White	JAN 12 1900	86	YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
FALLSTON PA	USA			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ins Agent				
12b. KIND OF BUSINESS OR INDUSTRY INSURANCE				
13a. STATE NJ 13b. COUNTY Lancaster 13c. CITY OR TOWN Quarryville				
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13e. STREET ADDRESS / ZIP CODE 225 S. Hillcrest Ave 17566				
14. FATHER'S NAME FIRST MIDDLE LAST				
DAVID MORRIS Beck				
15. MOTHER'S MAIDEN NAME Sarah Barbara Forney				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WW II 16b. SOCIAL SECURITY NO. 17. INFORMANT				
18. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Ventricular fibrillation DUE TO, OR AS A CONSEQUENCE OF (c) Coronary artery disease. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 3/20 1986 to 3/20 1986, that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. DATE SIGNED 3/20/86				
22c. SIGNATURE				
22d. DEGREE				
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22e. ADDRESS 12500, 6th & 10th Sts.				
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial				
23b. DATE 3-24-86				
23c. NAME OF CEMETERY OR CREMATORIAL Middletown Cem.				
23d. LOCATION CITY OR TOWN Middletown COUNTY Dauphin STATE Pa.				
24. FUNERAL DIRECTOR NAME Carl Reynolds, Jr. ADDRESS Quarryville, Pa.				
25a. DATE REC'D BY REGISTRY 3/21/86				
25b. REGISTRAR'S SIGNATURE				

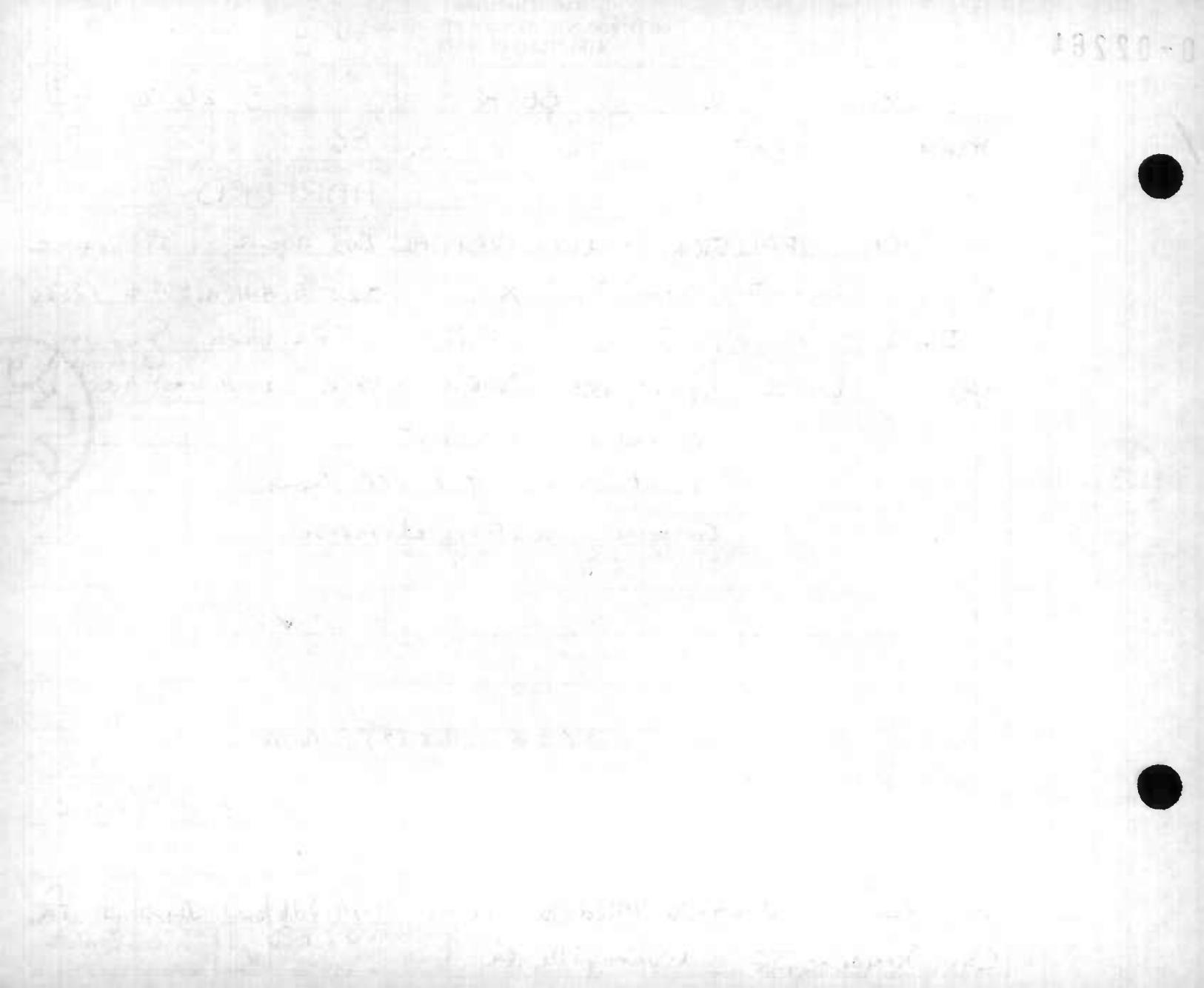
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return to the registrar papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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0-05584



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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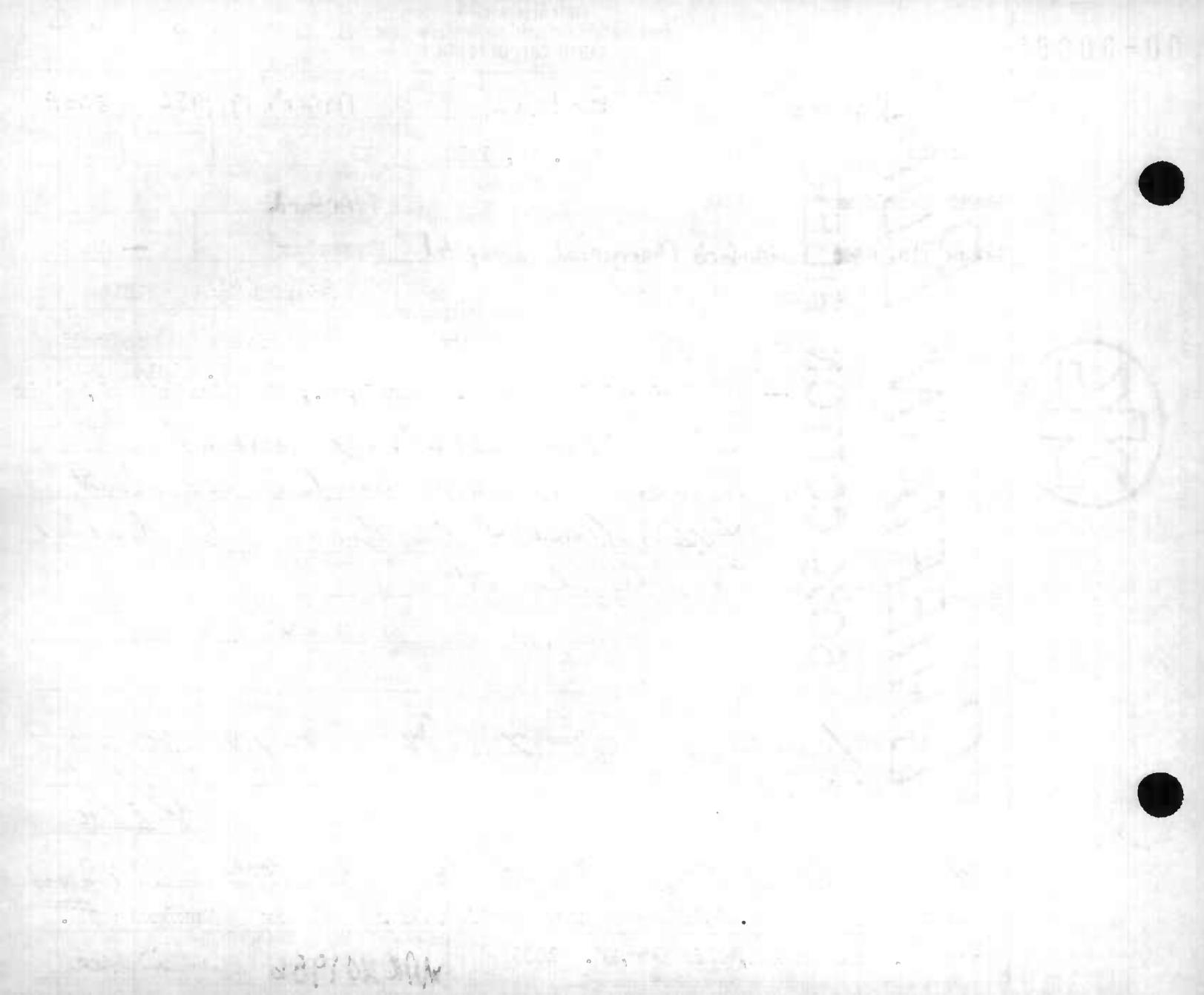
00-00995

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 8 5 6 5

REG. NO.

1. DECEASED NAME Blanche Almeda Bed Saul				2a. DATE OF DEATH MARCH 19, 1986	MONTH YEAR	DAY	2b. HOUR 8:10 A.M.			
3. SEX Female		4. RACE White	5. DATE OF BIRTH MONTH Dec. 19, 1912	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 73	YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford		
10. CITY OR TOWN OF DEATH Houre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY --				
13a. STATE Maryland		13b. COUNTY Harford	13c. CITY OR TOWN Bel Air	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 400 Schucks Road 21014				
14. FATHER'S NAME FIRST Jesse		MIDDLE Monroe	LAST Crouse	15. MOTHER'S MAIDEN NAME FIRST Mary		MIDDLE Catherine	LAST Woodruff			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 219-12-7741		17. INFORMANT Dean G. Bedsaul, Sr., 400 Schucks Road, BelAir		ADDRESS Md. 21014				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory arrest DUE TO OR AS A CONSEQUENCE OF Massive cerebrovascular accident DUE TO OR AS A CONSEQUENCE OF Hyper tension cardiovascular disease									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Carcinoma of the breast										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 1-18-86 to 3-19-86 , that (I) (we) last saw the deceased alive on 3-19-86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (In (we) add (did not) view the body after death.)										
22b. SIGNATURE D. J. Crouse		22c. DEGREE		22d. ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22e. DATE SIGNED 3-19-86		
22f. PHYSICIAN'S NAME (TYPE OR PRINT) H. Alexa Kowar M.D.		22g. ADDRESS 319 Belmont Ave. Harford Md.		22h. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 21, 1986	23c. NAME OF CEMETERY OR CREMATORIAL Oak Grove Baptist Cem.		23d. LOCATION CITY OR TOWN Bel Air	COUNTY Harford	STATE Md.			
24. FUNERAL DIRECTOR Howard K. McComas III, Abingdon, Md. 21009		25a. DATE REC'D. BY REGISTRAR Mar. 20, 1986		25b. REGISTRAR'S SIGNATURE W. J. McComas III						



072124

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 8 5 6 6

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
<u>Linwood</u>			<u>S.</u>	<u>BELT</u>		<u>3</u>	<u>1</u>	<u>86</u>	<u>11:42P.M.</u>			
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
<u>Male</u>		<u>Caucasian</u>	<u>5</u>	<u>30</u>	<u>11</u>	<u>74</u>						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>HARFORD County MD.</u>					
<u>Maryland</u>		<u>USA</u>										
10. CITY OR TOWN OF DEATH <u>FALSTON</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>FALSTON General</u>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Truck Driver</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Quinn Freight</u>					
13a. STATE <u>MD.</u>		13b. COUNTY <u>HARFORD</u>	13c. CITY OR TOWN <u>Kingsville</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>11703 Cedar Lane / 21087</u>						
14. FATHER'S NAME FIRST <u>Walter</u>		MIDDLE <u>Ellsworth</u>	LAST <u>Belt</u>	15. MOTHER'S MAIDEN NAME FIRST <u>Bertha</u>		MIDDLE	LAST <u>AMBROSE</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>--</u>		16b. SOCIAL SECURITY NO. <u>215 10 6746</u>			17. INFORMANT <u>Mrs. Ruth M. Belt,</u>		ADDRESS <u>11703 Cedar Lane Kingsville, Md. 21087</u>					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>						
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE PULMONARY EDema</u>						2 day.						
DUE TO, OR AS A CONSEQUENCE OF (c) <u>CONGESTIVE CARDIOMYOPATHY</u>						~1 year.						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. certify that (I) (this hospital) attended the deceased from <u>31-86</u> , to <u>31-86</u> , that (I) (we) last saw the deceased alive on <u>31-86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Barry Roth M.D.</u>		22c. DEGREE <u>MD</u>			22d. ATTENDING PHYSICIAN <u>X</u>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <u>3-1-86</u>	
22f. ATTENDANT'S NAME (TYPE OR PRINT) <u>Barry Roth M.D.</u>		22g. ADDRESS <u>2003 Rocksprings Rd. Forest Hill, Md. 21050</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE <u>3-5-1986</u>		23c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery		23d. LOCATION CITY OR TOWN <u>Parkville Baltimore Md.</u>		23e. COUNTY <u>Baltimore</u>		STATE		
24. FUNERAL DIRECTOR NAME E.F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087		25a. DATE REC'D. BY REGISTRAR <u>APR 06 1986</u>		25b. REGISTRAR'S SIGNATURE <u>Julie Bridges</u>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified about it.

EDUTO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon copies. Forges 1 and 2 should be detached for use at the burial permit. Then please remove carbon copies. Please print in capital letters.

IMPORTANT: If Item 21 is marked or item 22 is checked, the hospital or attending physician.

MEDICAL CERTIFICATION

1. STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 0 8 5 6 1

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
<i>Joseph</i>				<i>(nnn)</i>	<i>Bench</i>		<i>3</i>	<i>9</i>	<i>86</i>	<i>3:24 PM</i>	
1. SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		
Male		White		Oct. 22, 1933			52		MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Mauch Chunk, Pa.		USA					<i>Harford Co.</i>				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION Manager Self-Serv Supply Center			12b. KIND OF BUSINESS OR INDUSTRY US-govt.				
<i>Fallston</i>		<i>Fallston General Hospital</i>								21014	
13a. STATE Maryland		13b. COUNTY Harford	13c. CITY OR TOWN Bel Air	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			14. STREET ADDRESS / ZIP CODE 160 Royal Oak Drive, Apt. F.				
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST			
Andrew		—	Bench	Anna			—	Marchalk			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS				
Yes		Korea		207-24-6214			Joseph T. Bench, 26 Stallion Row, Warwick, Md.			21912	
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adeno CA Lung w/ supraclavicular lymph node</i>											
DUE TO, OR AS A CONSEQUENCE OF <i>meth el bilat pleu effusion.</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks.											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>2-10</i> , 19 <i>86</i> , to <i>3-9</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>3-9</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Parekh</i>		22c. DEGREE <i>MD</i>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <i>3-9-86</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>B. PAREKH MD.</i>		22e. ADDRESS <i>1908 Harford Rd. Fallston MD 21047</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>Mar. 12, 1986</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>St. George's Episcopal Cemetery Perryman</i>		23d. LOCATION CITY OR TOWN <i>Harford Md.</i>		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME <i>Howard K. McComas III, Abingdon, Md. 21009</i>		ADDRESS		25a. DATE REC'D. BY REGISTRAR <i>MAR 12 1986</i>		25b. REGISTRAR'S SIGNATURE <i>John Darden-Fordell</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return early papers, Pages 1 and 2 to the physician within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8	6	0	8	5	6
REG. NO.											
1. DECEASED NAME (TYPE OR PRINT) RAYMOND WALTER BENNETT				2a DATE OF DEATH 3/13/86	MONTH Mar	DAY 13	YEAR 1986	2b. HOUR 12 MZO			
3. SEX Male		4. RACE White	5. DATE OF BIRTH Jan. 24 1906	6. AGE (IN YEARS LAST BIRTHDAY) 79	IF UNDER 1 YEAR YRS.	IF UNDER 24 HRS MONTHS DAYS HOURS MIN.					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.							
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL				12a USUAL OCCUPATION Retired-IR Engineer					
13a STATE Md.		13b. COUNTY Harfard	13c. CITY OR TOWN Joppa	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 225 Kershaw Court 21085						
14. FATHER'S NAME FIRST Franklin				MIDDLE Bennett	LAST Charlott	MIDDLE Johnson	LAST Johnson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW11		17. INFORMANT Richard Bennett 225 Kershaw Court 21085	ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cod-pulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF <i>Acute ventricular fibrillation</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Chronic cerebral insufficiency</i> DUE TO, OR AS A CONSEQUENCE OF <i>Chronic cerebral insufficiency</i> (c)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		STATE			
22a. I certify that (I) this hospital diagnosed the deceased from 3/2/86 to 3/12/86 , that (I) (we) last saw the deceased alive on 3/2/86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not see anybody other death.											
22b. SIGNATURE		22c. DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Linda Freil		22f. ADDRESS 9604 Church St. Baltimore									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/15/86	23c. NAME OF CEMETERY OR CREMATORIAL Security Process Inc.		23d. LOCATION CITY OR TOWN Baltimore		23e. COUNTY Maryland	STATE			
24. FUNERAL DIRECTOR NAME Connelly Funeral Home		ADDRESS 300 Mace Ave. 21221	25a. DATE REC'D. BY REGISTRAR MAR 14 1986		25b. REGISTRAR'S SIGNATURE John Davidson Pendleton						

13001-00



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MEDICAL CERTIFICATION

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8608569
REG. NO.
3 1986
555 PM

1. DECEASED NAME <u>Margaret Bronikowski Blair</u>			2a. DATE OF DEATH <u>Mar. 3 1986</u>	MONTH March	DAY 3	YEAR 1986	2b. HOUR 555 PM
3. SEX <u>Female</u>	4. RACE <u>Female</u>	5. DATE OF BIRTH MONTH <u>Mar.</u> DAY <u>22</u> , YEAR <u>1898</u>	6. AGE (IN YEARS LAST BIRTHDAY) MONTHS <u>88</u> YRS	IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <u>Harfard</u>				
10. CITY OR TOWN OF DEATH <u>Havre de Grace</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <u>Harford Memorial Hospital</u>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <u>Md.</u> 13b. COUNTY <u>Harford</u> 13c. CITY OR TOWN <u>Churchville</u> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
14. FATHER'S NAME FIRST <u>Thomas</u>	MIDDLE LAST <u>Bronikowski</u>	15. MOTHER'S MAIDEN NAME FIRST <u>Catherine</u>	MIDDLE LAST <u>Bronikowski</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. N/A	17. INFORMANT ADDRESS Melvin J. Blair, 3643 Churchville Rd., Aberdeen, MD 21001					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO (b) AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Pneumonia DUE TO (c) AS A CONSEQUENCE OF BOP							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>March 3, 1986</u> to <u>March 3, 1986</u> . That (I) (we) last saw the deceased alive on <u>March 3, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>J. Lee</u> M.D.							
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. Lee</u>	22d. ADDRESS <u>Audon Med - Clyne & Leonore Grace</u>			22e. MEDICAL STAFF ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>Mar. 6, 1986</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cem.</u>	23d. LOCATION CITY OR TOWN <u>Baltimore City, Maryland</u>				
24. FUNERAL DIRECTOR NAME <u>Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3309</u>	25a. DATE REC'D. BY REGISTRAR <u>MAR 6 1986</u>	25b. REGISTRAR'S SIGNATURE <u>Landers</u>					

155.30

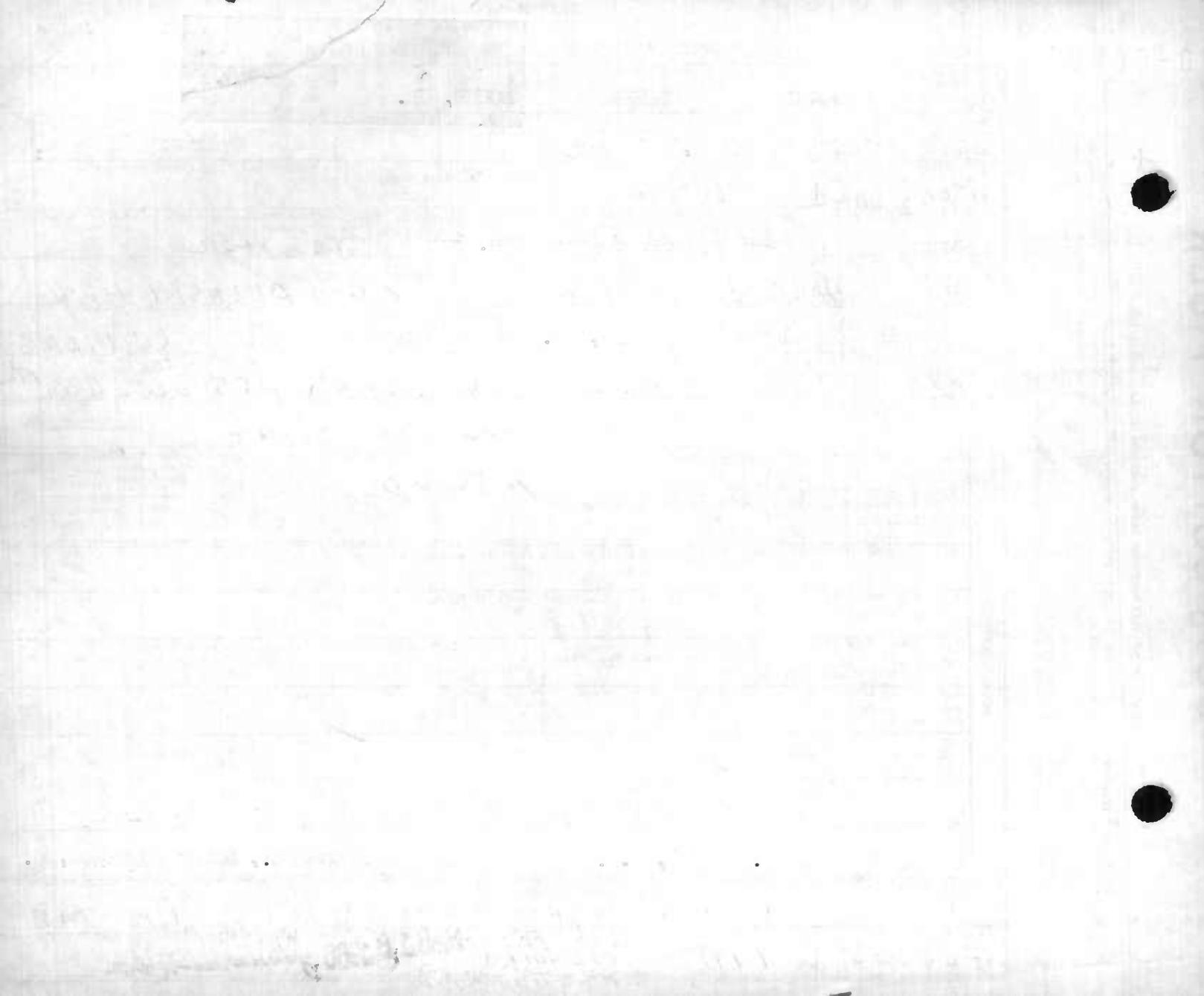
1200 MGRU Nde

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. FIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 3 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 08570					
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE KNOWN MONTH DAY YEAR			2b. HOUR					
			DENNIS CLAVEN BOONE, JR.						<input type="checkbox"/> ESTI- DEATH MATED <input type="checkbox"/>			19					
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d HOUR	
Male		Black		April 8, 1923		62 yrs.						February 19, 1986		PM 3:00			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8			9 BALTIMORE CITY OR COUNTY OF DEATH								
Maryland			USA			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Harford								
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY								
Joppa			402 Pulaski Highway Apt. #01			Janitor			21085-								
13a STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS							
MD			HARFORD		JOPPA		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			402 PULASKI Hwy							
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
FIRST Dennis Claven LAST Boone, Sr.			FIRST Sarah MIDDLE Jane LAST WILLIAMS			217-22-6050			MILDRED EPPS			STAR ST EDGEWOOD MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <i>ASCOV</i> DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?											
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE											
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <i>Luis E. Renjel</i>			E (SPECIFY) M.D. Deputy			MEDICAL EXAMINER			DATE SIGNED 2-19-86								
EXAMINER'S NAME (TYPE OR PRINT)			Luis E. Renjel, M.D.			ADDRESS 464 Alliance St., Havre de Grace, Md.			21078								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 2-24-86			23c. NAME OF CEMETERY OR CREMATORY HARFORD CITY			23d. LOCATION CITY OR TOWN BELAIR HA STATE MD								
24 FINERAL DIRECTOR NAME <i>GEORGE W. TITTLE</i>			ADDRESS 3836 9th Fed MAR 18 1986			C'D. BY REG. PAR			25b. REGISTRAR'S SIGNATURE <i>John J. Tittle Jr.</i>								
(VR A15 ME (5))																	



00-00738

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 8 5 7 1

REG. NO.

1. FOR
STATE
REGISTRAR

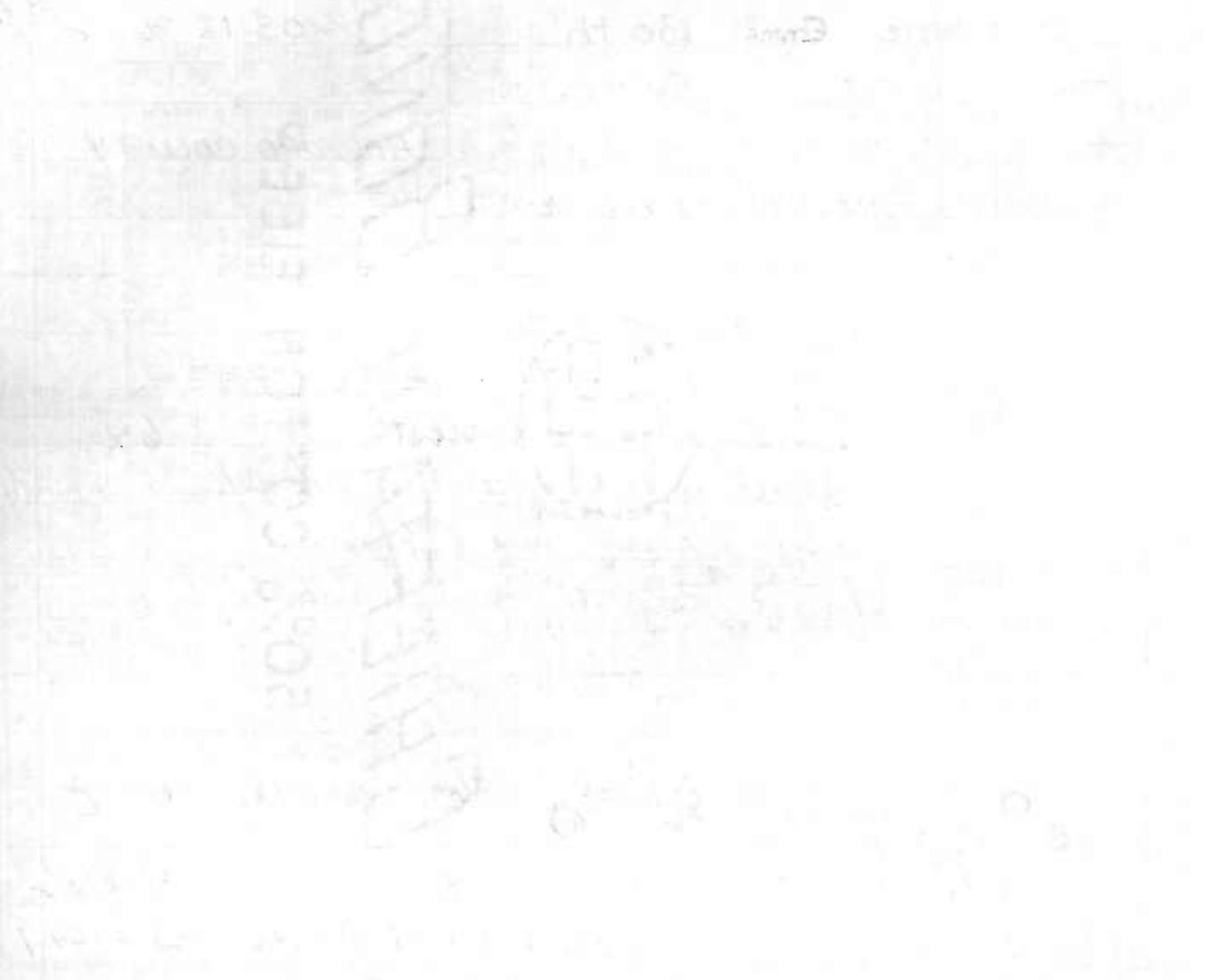
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
<i>Josephine Emma Booth</i>						<i>03 18 86</i>				<i>6 35 A</i>				
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS				
FEMALE		WHITE	<i>FEBRUARY 27, 1912</i>			74	YRS.	MONTHS	DAYS	HOURS	MIN.			
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
VIRGINIA		USA				<i>HARFORD COUNTY MD.</i>								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
<i>FALLSTON</i>		<i>FALLSTON GENERAL HOSPITAL</i>			<i>HOMEMAKER</i>			<i>21040</i>						
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE								
MD		HARFORD	EDGEWOOD	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		616 LONGWOOD COURT								
14. FATHER'S NAME HUSBAND		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME										
HENRY			KREBS	MAUDE										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS								
NO		216 24 6740		MR. HAROLD J. BOOTH		SAME AS #13								
18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) <i>Cardiovascular Arrest</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Small cell cancer of the lung with extensive 2 months metastases</i>								<i>6 35 A</i>				
		DUE TO, OR AS A CONSEQUENCE OF (c) <i>Severe anemia and Cachexia</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED <small>NOT WHILE AT WORK</small>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE				
22a. I certify that (the hospital) attended the deceased from <i>Feb. 25 86</i> , to <i>Mar. 18, 86</i> , that (we) last saw the deceased alive on <i>Mar. 17, 86</i> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>Albert S.C. Sun, M.D.</i>		22c. DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <i>3/18/86</i>							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Albert S.C. Sun, M.D.</i>		22f. ADDRESS <i>1800 Harford Rd. Fallston, MD 21047</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 20MARCH86		23c. NAME OF CEMETERY OR CREMATORIAL HOLLY HILL MEMORIAL GDNS.		23d. LOCATION CITY OR TOWN		CITY OR TOWN		COUNTY	STATE			
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078		ADDRESS			25a. DATE REC'D. BY REGISTRAR <i>MAR 19 1986</i>		25b. REGISTRAR'S SIGNATURE <i>Ronald Pendleton</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be searched within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached by use of the horizontal perforation. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene given to burial, cremation, or removal.

IMPORTANT: If item 21 is marked **B** or **S** any injury or other traumatic event the medical examiner should be notified.

76500-00



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, then please remove carbon paper. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be retained by the funeral director. Page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 08572				
										REG. NO.				
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR				
1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	July 5, 1905			3-12-86		7:30 AM			
3 SEX			4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Female			White		July 5, 1905			80			YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Md.			U.S.A.					HARford County						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
HARford & Grace			HARford Memorial Hospital							Homemaker			-	
13a. STATE Md.			13b. COUNTY Harford		13c. CITY OR TOWN Fallston			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1406 Ryan Rd. 21047			
14. FATHER'S NAME FIRST James			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST Coffay			MIDDLE	LAST Margaret	ADDRESS Davis				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR ORDATES) 213-36-8814		17. INFORMANT Patricia A. Palmer (dghtr) same address									
18. CAUSE OF DEATH (Enter only one cause per line for Part I, II, and III) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sudden heart failure</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first (b) <i>Intestinal obstruction</i>														
DUE TO, OR AS A CONSEQUENCE OF (c) <i>G.I. bleeding</i>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1-10														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____ 19_____. to _____ 19_____. that (I) (we) last saw the deceased alive on _____ 19_____. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										22c. DATE SIGNED <i>Sept 6</i>				
22d. SIGNATURE <i>J.T. Lee</i>										DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J.T. Lee</i>										ADDRESS Elmwood Med. Ctr., HARford Grace				
23a. BURIAL, CREMATION, REMOVAL (SPECIES)			23b. DATE Burial 3/15/86		23c. NAME OF CEMETERY OR CREMATORIAL Moreland Mem. Park			23d. LOCATION CITY OR TOWN Baltimore		COUNTY	STATE Md.			
24. FUNERAL DIRECTOR NAME SCHMIDT Funeral Home, Inc. ADDRESS 9705 Belair Rd., Balto. Md. 21236			25a. DATE RECEIVED FOR REGISTRATION MAR 14 1986			25b. REGISTRAR'S SIGNATURE <i>J. Lee</i>								

83200-00

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40TH DIVISION

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40TH DIVISION

066216

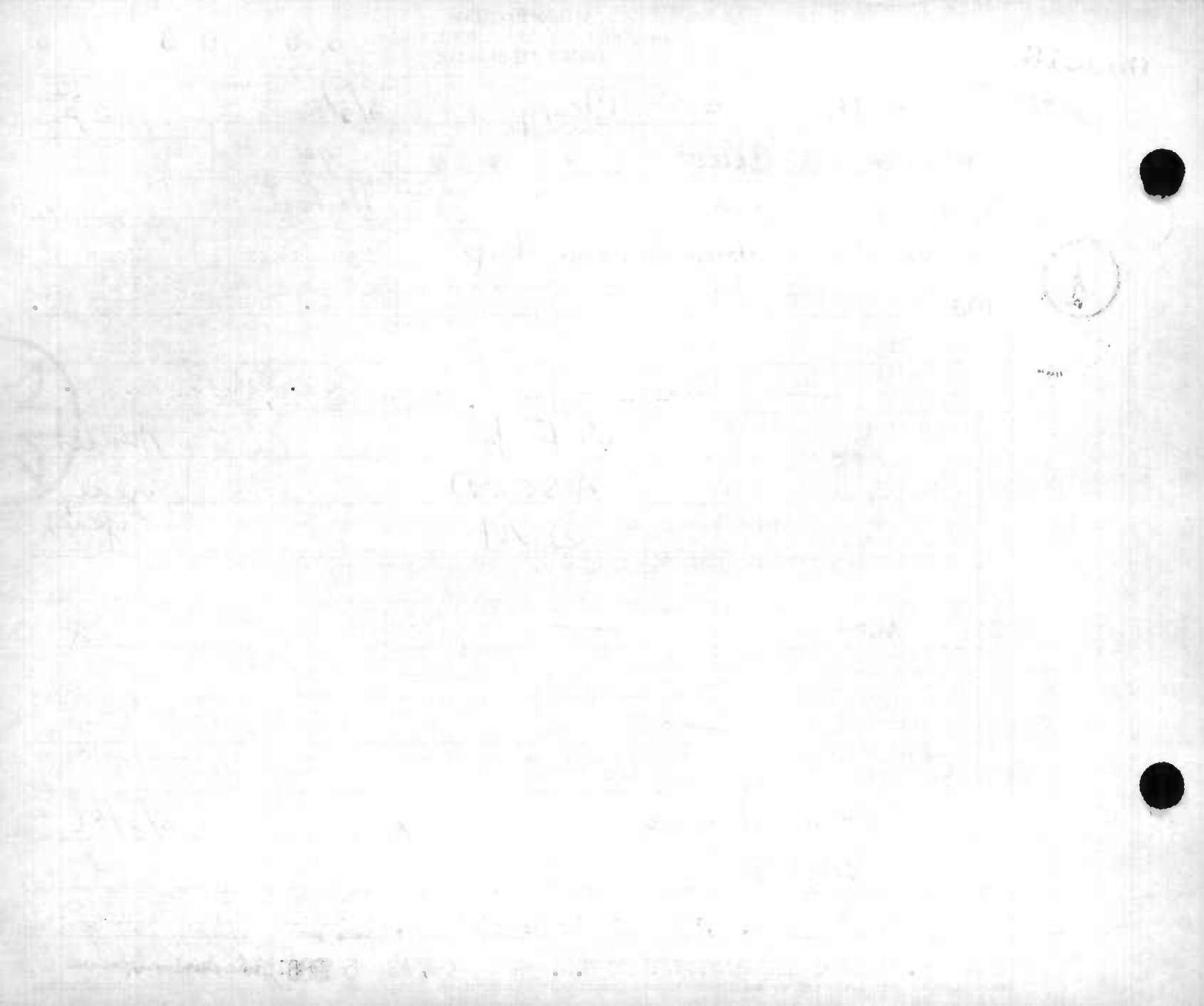
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 08573
REG. NO.

1. DECEDENT'S NAME Ruth			FIRST BETTY	MIDDLE Cleary	LAST	2a. DATE OF DEATH 3/3/86	MONTH YEAR	DAY	YEAR	2b. HOUR 3 p.m.					
3. SEX Female		4. RACE White	5. DATE OF BIRTH MONTH 9 DAY 12 YEAR 11			6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.				
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Hartford							
10. CITY OR TOWN OF DEATH Bellair, Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hosp			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Home							
13. STATE MARYLAND		13b. COUNTY HARFORD	13c. CITY OR TOWN BEL AIR	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 21014 619 N. Fountain Green Rd.								
14. FATHER'S NAME Charlie		FIRST M	MIDDLE Jennings	LAST Tilda	15. MOTHER'S MAIDEN NAME V.F.b			16. ADDRESS 619 N. Fountain Green Rd. Bel Air, Maryland 21014			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes				
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-36-4457			17. INFORMANT Ivan C. Cleary			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) V.F.b							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD			DUE TO, OR AS A CONSEQUENCE OF (c) D.M.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) —										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —			21f. LOCATION STREET —			CITY OR TOWN —		COUNTY —	STATE —				
22a. I certify that (I) (the hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Deborah Jason		22c. DEGREE —			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 3/3/86							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VASSAR		22e. ADDRESS —													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Mar. 6, '86		23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gds.			23d. LOCATION CITY OR TOWN Bel Air		COUNTY Harford	STATE Maryland					
24. FUNERAL DIRECTOR HOWARD K. MCCOMAS III FUNERAL HOME P.A.		25a. DATE REC'D. BY REGISTRAR 5/1986			25b. REGISTRAR'S SIGNATURE Jessie L. Johnson-Pender										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

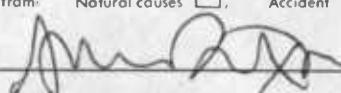
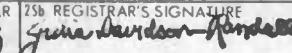
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Return and 2 could be filed than 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER CERTIFICATE. PAGES 1AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 08574
1- STATE REGISTRAR			DECEASED NAME (TYPE OR PRINT)			FIRST GARRY R. COLEMAN			LAST			2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR
3 SEX Male	4 RACE Black	5 DATE OF BIRTH MONTH DAY YEAR	Jan. 12, 1956	6 AGE (IN YEARS LAST BIRTHDAY)	30 YRS.	7 IF UNDER 1 YR. MONTHS	8 IF UNDER 24 HRS. DAYS	9 IF UNDER 24 HRS. HOURS	10 IF UNDER 24 HRS. MIN.	2b. DATE OF ESTI- DEATH MATED	3-26/27/86 M	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford County			
10. CITY OR TOWN OF DEATH Aberdeen			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) off of Rt. 22			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-Employed			12b. KIND OF BUSINESS OR INDUSTRY Musician			
13a. STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Silver Spring			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 20907 3110 Whispering Pine Dr.		
14. FATHER'S NAME FIRST Clyde MIDDLE R. LAST Coleman						15. MOTHER'S MAIDEN NAME Matilda (Mother) Gandy						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES NO			16b. SOCIAL SECURITY NO. 396-60-0782			17. INFORMATION Matilda Coleman Racine, Wis. 53403						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wounds of head (unspecified weapon) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 3-26/27 1986			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject shot.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) off of road			21f. LOCATION STREET Rt. 22 CITY OR TOWN Aberdeen COUNTY Harford STATE MD						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE 												
EXAMINER'S NAME (TYPE OR PRINT)			Ann M. DIXON, M.D.			TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER			DATE SIGNED 3-30-86			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 4/4/86			23c. NAME OF CEMETERY OR CREMATORIAL Graceland Cem.			23d. LOCATION CITY OR TOWN Racine COUNTY Racine STATE Wis.			
24. FUNERAL DIRECTOR Fleming Funeral Service			ADDRESS E. Barnes 21018			25a. DATE REC'D. BY REGISTRAR APR 01 1986			25b. REGISTRAR'S SIGNATURE 			
BP												
DHMH - 17 (VR A15 ME (5))												



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00-01170

REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 3, RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED				MONTH	DAY	YEAR	2b. HOUR
<i>Genevieve</i>			<i>M.</i>	<i>Crawford</i>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD				MONTH	DAY	YEAR	2d. HOUR
<i>F</i>	<i>W</i>	<i>7 20 06</i>	<i>79 yrs.</i>			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH				10. CITY OR TOWN OF DEATH		
<i>Maryland</i>		<i>USA</i>			<input type="checkbox"/>	<input type="checkbox"/>	<i>HARFORD</i>				<i>HARFORD</i>		
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN AUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
<i>HARFORD Memory</i>													
13a. STATE		13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS		14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
<i>MD</i>		<i>HARFORD</i>	<i>HARFORD</i>			<i>916 Wakefield Dr</i>		<i>Marion Lee</i>			<i>Laura</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
<input type="checkbox"/> No		<i>213-705-841</i>		<i>Hospital Records</i>									
IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		CORONARY Heart Disease									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		ASCU D.									
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
										<input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		CITY OR TOWN		CITY OR TOWN			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		<i>Lew E. Renfyl</i>		TITLE (SPECIFY) M.D.		Deputy		MEDICAL EXAMINER		DATE SIGNED <i>3-20-86</i>			
EXAMINER'S NAME (TYPE OR PRINT)		<i>Lew E. Renfyl</i>		ADDRESS		<i>464 Alliance St</i>		<i>Havre de Grace</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE			
Burial		<i>Mar. 23, 1986</i>		<i>Angel Hill Cemetery</i>		<i>Havre de Grace</i>		<i>Harford</i>		<i>Md.</i>			
24. FUNERAL DIRECTOR NAME		ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Lee A. Patterson & Son Perryville, Md.				<i>MAR 24 1986</i>				<i>Levison Pendle</i>					
DHMH - 17 (VR A15 ME (5))													

85110-00



00-02294

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page # may be retained by the hospital or attending physician.

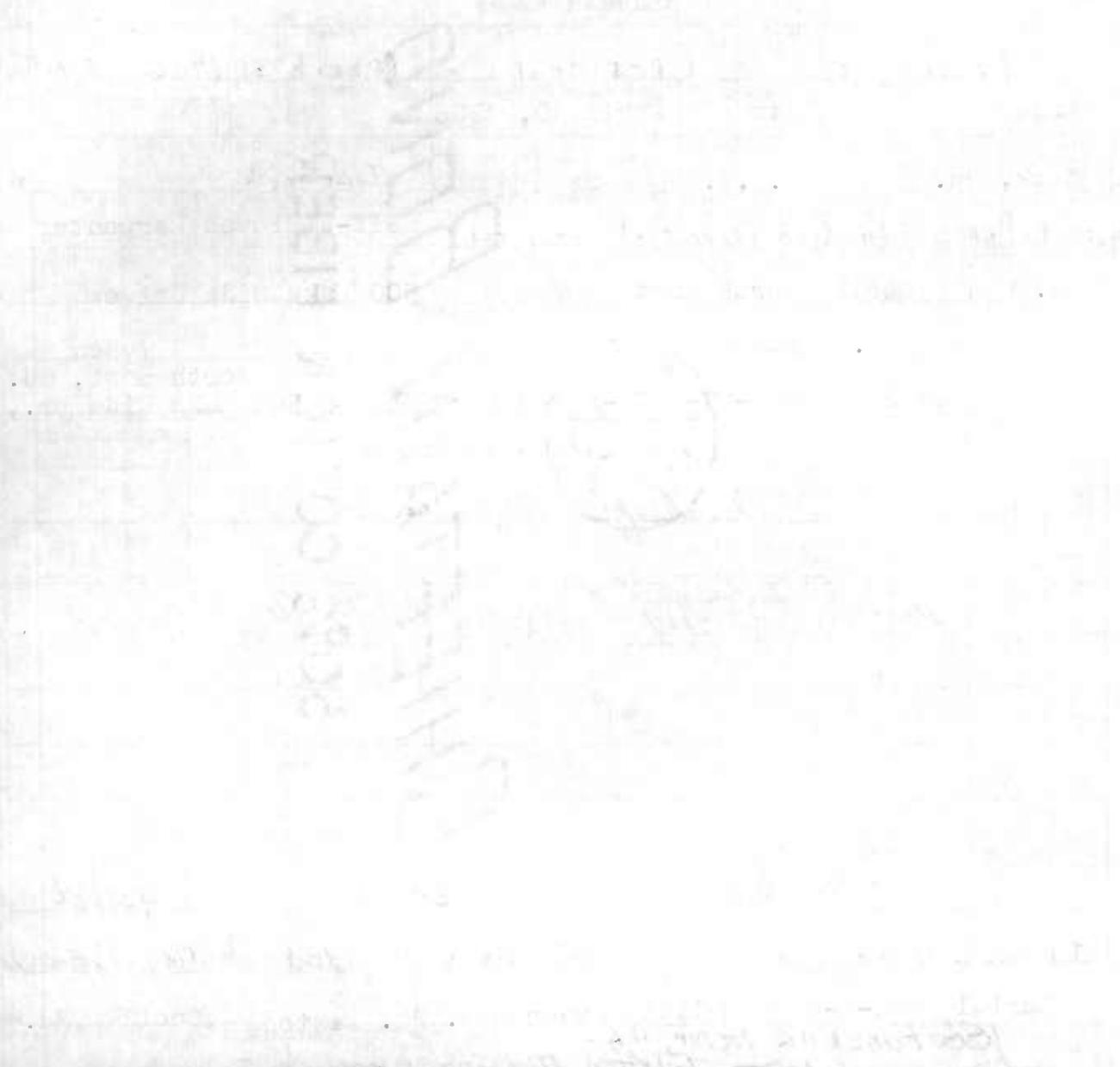
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial permit. Then please remove cover from Part I and Part II and attach them together. Part I should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If Item 21 is marked or if Item 18 contains any injury, or other traumatic event, the medical examiner must be notified at the time of death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8608576		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	7b. HOUR		
Thomas E. Creswell					Creswell	March 31, 1986				8:40 A.M.		
3. SEX Male			4 RACE White	5 DATE OF BIRTH Month April 10, 1906		6 AGE (IN YEARS LAST BIRTHDAY) 79		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Elk Neck, Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford		MD.			
10 CITY OR TOWN OF DEATH Our de Grace			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a. USUAL OCCUPATION Self-employed		12b. KIND OF BUSINESS OR INDUSTRY Carpenter		21901			
13a. STATE Md.			13b. COUNTY Cecil		13c. CITY OR TOWN North East		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 500 Lake Side Drive			
14. FATHER'S NAME FIRST Thomas			MIDDLE A.	LAST Creswell	15. MOTHER'S MAIDEN NAME Mary				LAST Tyson			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. WW 2		17. INFORMANT Dorothy Gregson		ADDRESS North East, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Septicemia, a multiple Myeloma</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>multiple Myeloma</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>Cardiac failure due to chronic Heart disease</i>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN,	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Bruin L. Wachman</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/31/86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) IRUIN L. Wachman			22e. ADDRESS 4075 Union Ave, Harford de Grace Md A.21028									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-3-86		23c. NAME OF CEMETERY OR CREMATORIAL Gilpin Manor Mem. Pk.		23d. LOCATION CITY OR TOWN Tilton		COUNTY	STATE		
24. FUNERAL DIRECTOR Fect Funeral Home, P.A. EIKTON, MD			ADDRESS		25a. DATE REC'D. BY REGISTRAR APR 02 1986		25b. REGISTRAR'S SIGNATURE <i>J. J. Fawcett</i>					

ACCESSION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

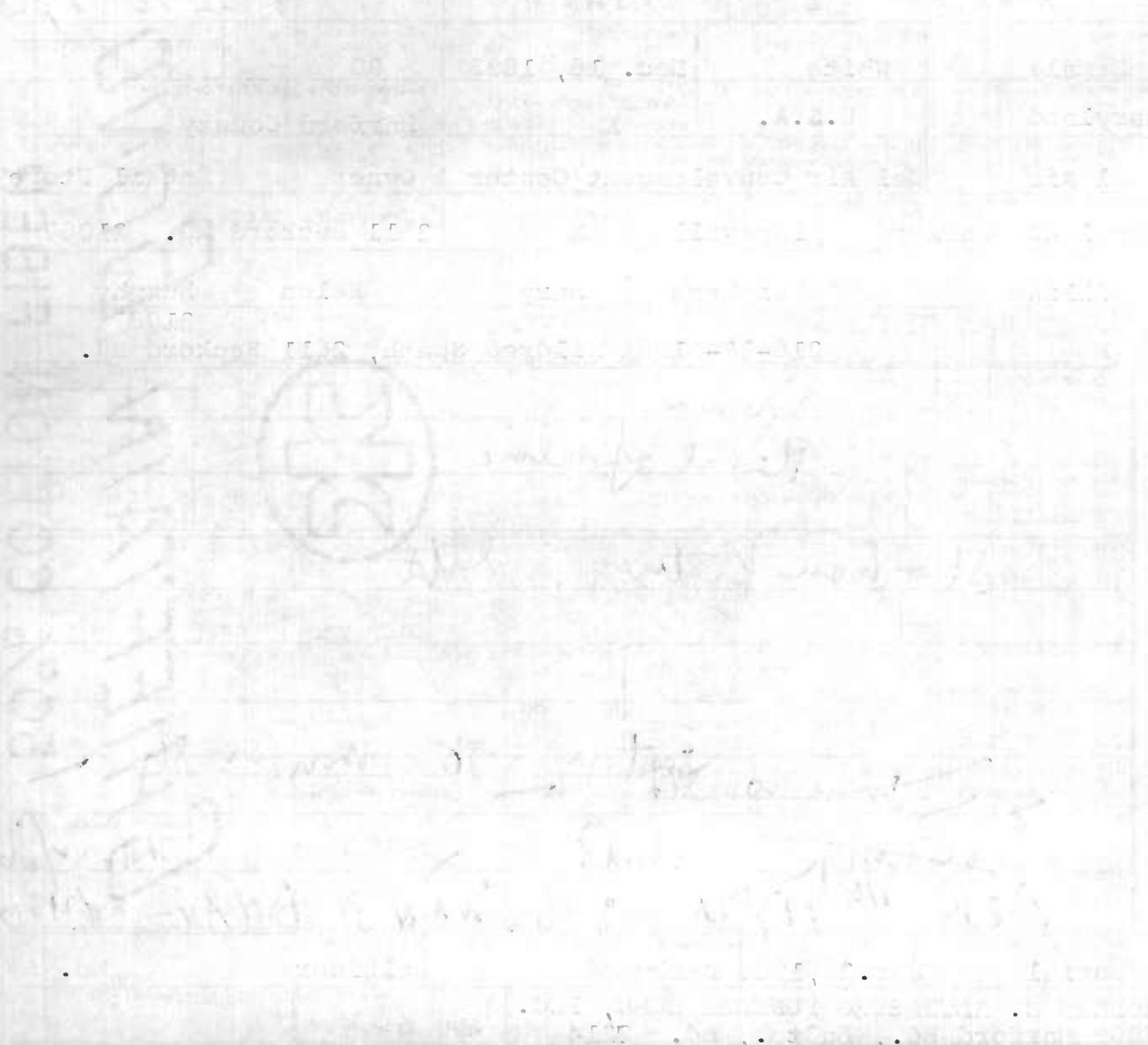
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death.

IMPORTANT: If item 21 is marked (b) signs any injury, or other traumatic event, the medical certification section must be completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8608571			
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 3 22 86							2b. HOUR 8:15 P.M.			
I. DECEASED NAME (TYPE OR PRINT) MARIE L. DEMM			MIDDLE			LAST		2a. DATE OF DEATH MONTH DAY YEAR 3 22 86			2b. HOUR 8:15 P.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH Dec. DAY 18, YEAR 1895			6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS		7. IF UNDER 1 YEAR MONTHS DAYS			8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.						
10. CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Air Convalescent Center		12a. USUAL OCCUPATION Owner			12b. KIND OF BUSINESS OR INDUSTRY Retail Store						
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Kingsville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2611 Reckord Rd. 21087				
14. FATHER'S NAME William		FIRST MIDDLE LAST Leimbach		15. MOTHER'S MAIDEN NAME Mary			16. SOCIAL SECURITY NO. 218-32-31084		17. INFORMANT Mildred Spath, 2611 Reckord Rd.		ADDRESS 21087		
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		18b. APPROXIMATE (INTERVAL) BETWEEN ONSET AND DEATH		18c. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			18d. DUE TO, OR AS A CONSEQUENCE OF (b) Mental Fatigue						
18e. IMMEDIATE CAUSE (a) Mental Fatigue				18f. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>Sept. 17, 1986</u> to <u>Mar. 20, 1986</u> , that (II) (we) lost saw the deceased alive on <u>Mar. 20, 1986</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If you did not see the body after death, check here <input type="checkbox"/>													
22b. SIGNATURES		22c. DEGREE M.D.		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED Mar. 22, 1986							
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <u>BEN STEYER</u>		22g. ADDRESS 846 S. MAIN ST. BEL AIR, MD 21014											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 26, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Parkwood		23d. LOCATION CITY OR TOWN Baltimore		23e. COUNTY		23f. STATE Md.			
24. FUNERAL DIRECTOR ROBERT C. ALtenburg FUNERAL HOME, INC. 6009 Harford Rd., Balto., Md. 21214		25a. DATE REC'D. BY REGISTRAR MAR 26 1986		25b. REGISTRATION NATURE									
BP _____													
DHMH - 16 60M 7/84 (VRA 15, 4)													

31410-00



86 08518

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1 - STATE REGISTRAR				2d. DATE OF DEATH MONTH DAY YEAR								7b. HOUR			
1. DECEASED NAME FIRST MIDDLE LAST				March 5th 1986								2b. 05 27 AM			
6		Laurie V Davison		DAVISON											
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)				7b. HOUR			
FEMALE		WHITE		MONTH DAY YEAR				75 YRS.				27 05 27 AM			
DECEMBER 7, 1910		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH				MD.					
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
W.VA.		USA		Havre de Grace				Harford Mem. Hospital				HOMEMAKER			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS / ZIP CODE			
MD		HARFORD		HAVRE de GRACE				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				804 CHESAPEAKE DRIVE 21078			
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME											
JERRY S. AMBROSE		FLOSSIE B. WALTERS													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
NO				219 42 9366				ORIE W. DAVISON, 150 S. FREEDOM LANE, HdG, MD 21078							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))															
PART I. DEATH WAS CAUSED BY: STOCK APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF A ZOTEMIA															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b)															
DUE TO, OR AS A CONSEQUENCE OF (c) PIMAL Hypertension															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Pneumonia, GI Bleeding															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
		HOUR A.M. MONTH DAY YEAR				P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION				CITY OR TOWN COUNTY STATE					
AT WORK						STREET									
22a. I certify that (I) (this hospital) attended the deceased from 3-5 1986 to 3-5 1986, that (I) (we) last saw the deceased alive on 3-5 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED					
Dante Monakil										3/5/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				NAME				DANTE MONAKIL, M.D.					
Dante Monakil															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL				23d. LOCATION				CITY OR TOWN		COUNTY STATE	
BURIAL		7MARCH86		BEL AIR MEMORIAL GARDENS				BEL AIR, HARFORD CO., MARYLAND							
24. FUNERAL DIRECTOR		NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE	
		MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078								MAR 7 1986				J. J. Pendell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

BP _____

DHMH - 16 60M 7-B4 (VRA 15, 4)

50-630

Sept 20

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and certified by the hospital or attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 3 should be detached for use as the burial and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 86 08579		
1. DECEASED NAME <small>(TYPE OR PRINT)</small>		FIRST Louise S	MIDDLE	LAST DEMAR	20. DATE OF DEATH 3-28-86		
3. SEX FEMALE	4. RACE White	5. DATE OF BIRTH MONTH Feb. DAY 19 YEAR 1906		20. MONTH	DAY	YEAR	26. HOUR 10 AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	
10. CITY OR TOWN OF DEATH Havre de Grace Harford Memorial Hospital		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <small>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)</small>		12a. USUAL OCCUPATION Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 3a. STATE Maryland		13b. COUNTY Cecil	13c. CITY OR TOWN Perryville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1505 Frenchtown Road 21904		MD.
14. FATHER'S NAME FIRST John MIDDLE Joseph LAST Smith		15. MOTHER'S MAIDEN NAME FIRST Pearl MIDDLE Eliza LAST Ferguson		ADDRESS 17019			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT Bernice Rakes, RD1, Dillsburg Penna.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No	218-18-5686						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypertensive arteriolesclotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/25/86 to 3/28/86, that (I) (we) last saw the deceased alive on 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (not) view the body after death.							
22b. SIGNATURE DR. SANG W. KIM, M.D.							
22c. DEGREE							
22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22e. ADDRESS 308 S. Union Ave. Havre de Grace, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE 4/1/86	23c. NAME OF CEMETERY OR CREMATORIAL Mount Erin Cemetery	23d. LOCATION CITY OR TOWN Havre de Grace Harford Md.	23e. COUNTY 21028	STATE		
24. FUNERAL DIRECTOR Lee A. Patterson & Son Perryville, Maryland	ADDRESS		25. DATE RECEIVED BY REGISTRAR 140 APR 09 1986		26. REGISTRATION NUMBER		
BP							
DHMH - 16 60M 7/84 (VRA 15, 4)							

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00-100736

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 8 5 8 0

REG. NO.

DECEASED NAME (TYPE OR PRINT)			FIRST <i>DANIEL</i>	MIDDLE <i>Joseph</i>	LAST <i>DePriest</i>			DATE OF DEATH MONTH <i>OCT.</i> DAY <i>27,</i> YEAR <i>1938</i>	MONTH YEAR	DAY	YEAR	2b HOUR 44 AM
1. SEX <i>Male</i>		4 RACE <i>White</i>	5. DATE OF BIRTH MONTH <i>OCT.</i> DAY <i>27,</i> YEAR <i>1938</i>			6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>HARFORD</i>			MD.	
10. CITY OR TOWN OF DEATH <i>HARFORD</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>HARFORD Mem. Hospital</i>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>DISABLED</i>			12b. KIND OF BUSINESS OR INDUSTRY				
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>MARYLAND</i>		14. COUNTY <i>HARFORD</i>	15. CITY OR TOWN <i>ABERDEEN</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <i>632 ROGERS ST. / 21001</i>					
14. FATHER'S NAME FIRST <i>JOHN</i>		MIDDLE <i>ALFRED</i>	LAST <i>DEPRIEST</i>	15. MOTHER'S MAIDEN NAME FIRST <i>MARGARET</i>			MIDDLE <i>MARY</i>	LAST <i>DEPRIEST</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? UNKNOWN <i>NES</i>		16b. SOCIAL SECURITY NO. <i>215-34-6606</i>			17. INFORMANT <i>CLORA A. DEPRIEST, SAME AS ABOVE</i>			ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for Part I, II and III) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-pulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Laeueuec's cirrhosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Acute Pleural effusion, bilat. pneumonia</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>None</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>3/16</i> , 19 <i>86</i> , to <i>3/17</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>3/16</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) (did not) view the body after death												
22b. SIGNATURE <i>Charles J. Foley Jr. M.D.</i> DEGREE CHARLES J. FOLEY JR. M.D. MEDICAL DIRECTOR <input checked="" type="checkbox"/> ATTENDING PHYSICIAN <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												
22c. DATE SIGNED <i>3/17/86</i>												
22d. THE PHYSICIAN'S NAME, TYPE OF PHYSICIAN <i>Charles J. Foley Jr. M.D.</i>		22e. ADDRESS <i>BEL AIR MEM. Gdns.</i>			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>			23b. DATE <i>MAR. 20, 1986</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>BEL AIR MEM. Gdns.</i>	23d. LOCATION CITY OR TOWN <i>BEL AIR</i>	23e. COUNTY <i>HARFORD</i>	
24. FUNERAL DIRECTOR NAME <i>JARRING FUNERAL HOME, P.A., ABERDEEN, MD</i>		ADDRESS <i>21001-3889</i>			25a. DATE REC'D. BY REGISTRAR <i>MAR. 19, 1986</i>			25b. REGISTRAR'S SIGNATURE <i>John</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for entry in the funeral director's file. Then please remove certificate. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

REPORTANT: If item 21 is marked as being 8 days after injury, or other traumatic event, the medical examiner will be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be held within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 0 8 5 8 1
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
<i>JAMES D. Deran</i>						3	1	86		12:45AM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male		White		10	5	06	79			YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
W. Virginia		U.S.					<i>Harford</i>					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SAME FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
90 Harford Center		Citizens Nursing Home					Agent			Insurance		
13a. STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Pileville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1021 Old Pileville Rd. 21132				
14. FATHER'S NAME J.		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Alice								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. No 179-09-6530		17. INFORMANT Mr. Charles H. Deran		18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio respiratory arrest</i>		ADDRESS Same as #13			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
						DUE TO/DUE AS A CONSEQUENCE OF (b) <i>Bronchopneumonia</i>						
						DUE TO/DUE AS A CONSEQUENCE OF (c) <i>Alzheimer's disease</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 18 <i>arteriosclerotic cardiovascular disease</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED <i>At home</i>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>At home</i>		21f. LOCATION STREET <i>11-19 18</i>		CITY OR TOWN <i>3-24</i>		COUNTY <i>19-86</i>		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>2/1/86</i> to <i>3-24-86</i> , that (I) (we) last saw the deceased alive on <i>2/1/86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, check here.)												
22b. SIGNATURE <i>John D. Deran</i> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 3/1/86												
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John D. Deran</i>		22d. ADDRESS <i>319 No. Union Ave Hdg 14d 21078</i>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 3/1/86		23c. NAME OF CEMETERY OR CREMATORIAL Balto., Md.		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Anatomy Board		ADDRESS		25a. DATE REC'D. BY REGISTRAR MAR 11 1986		25b. REGISTRAR'S SIGNATURE <i>Jeanne Davidson Pendleton</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be deposited by the funeral director in the burial vault or casket. Then please remit payment. Page 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked on Item 18, show any injury or other traumatic event the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8008582				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
Edith			Irene	Dodson		March	19	1986		30 10 p.m.				
2. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR				
Female			WHITE	MONTH	DAY	YEAR	72	YRS	MONTHS	MONTHS	IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
VIRGINIA			U.S.A.						Harford MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Harford Grace			Harford Memorial Hospital			HOMEMAKER								
13a. STATE			13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
Md.			Harford	Aberdeen			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			25 SWAN Street / 21001				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
SAMPSON W. BEAVERS			Neue			N/A			216-16-0037			FRANC W. DODSON, 133 BRANNON RD., ABERDEEN MD 21001		
18. CAUSE OF DEATH (Enter only one cause per line for Part 1b, and if PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b) multi-system failure, c CHF, pneumonia									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (c) Renal failure & B.M.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 2-5, 1986, to 3-19, 1986, that (I) (we) lost saw the deceased alive on 3-19, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.														
22b. SIGNATURE			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED					
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY STATE		
Burial			MAR. 22, 1986			Bel Air Mem. Gardens.			Bel Air			Harford MD		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
TAKING FUNERAL HOME, DA, ABERDEEN, MD 21001-3389						MAR 24 1986						Julia Davidson Pendleton		

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00-004851 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

851 08583

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	26 HOUR
Nelson R				Dorsey	March 12, 1986			10 4	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
M		BLACK		7 5 28	57			MONTHS DAYS	
7a BIRTHPLACE (COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS	
HARFORD MD		USA			Harford			MONTHS DAYS	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Havre de Grace		Harford Memorial Hosp		Const Wkr			21034		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE		
MD		HARFORD		DARLINGTON		YES <input type="checkbox"/>	3315 Cedar Ch Rd		
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			LAST	
EDWARD		E	Dorsey		Parline			AKINS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS		
YES		113050216300669		CATHRINE DORSEY			3315 Cedar Ch Rd DARLINGTON		
18. CAUSE OF DEATH (Enter only one cause per line 18 (a), (b), and (c)) PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Prob Pulmonary Embolism pts MD			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.		(b)					
				DUE TO, OR AS A CONSEQUENCE OF					
				(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		Nephritis, pneumonia							
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		19d. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/12/86, 1986, to 3/12/86, 1986, that (I) (we) last saw the deceased alive on 3/12/86, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		R. de los Santos		DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS				3-12-86	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN	23e. COUNTY	23f. STATE		
BURIAL		3-15-86	BURKLEY Cem		DARLINGTON	HARFORD	MD		
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
GEORGE W TITTLE		JARRETTSVILLE MAR 17 1986							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 will be used with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 28 shows any injury, or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 8608584	
1. FOR STATE REGISTRAR			2. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
1. DECEASED NAME FIRST MIDDLE LAST			March 14, 1986				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
				Sept. 23, 1917		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County	
10. CITY OR TOWN OF DEATH Belair		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 508 Camelot Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Belair		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				13e. STREET ADDRESS / ZIP CODE 508 Camelot Drive 21014	
Lyman Dwight McGreevy		Blanche Mae Burton				ADDRESS	
6a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 217-03-9501		17. INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min	
<p>18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u></p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last</p> <p>(b) <u>Pulmonary metastases</u></p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c) <u>Breast cancer</u></p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>February 19 85</u> to <u>March 19 86</u> , that (I) (we) last saw the deceased alive on <u>Jan. 14 19 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <u>L. Austin Doyle MD</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Austin Doyle</u>		MD		22e. ADDRESS <u>University Hospital Baltimore, Maryland</u>		22c. DATE SIGNED <u>3/17/86</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>3/17/86</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Woodlawn</u>		23d. LOCATION CITY OR TOWN <u>Baltimore</u> COUNTY <u>Maryland</u> STATE	
24. FUNERAL DIRECTOR NAME <u>Leonard J. Ruck Inc.</u>		ADDRESS <u>Baltimore, Maryland</u>		25a. DATE REC'D. BY REGISTRAR <u>MAR 18 1986</u>		25b. REGISTRAR'S SIGNATURE <u>Julie Deirdre Doyle</u>	

00000-00

day after today

beginning

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entirely certain (or person interviewed)

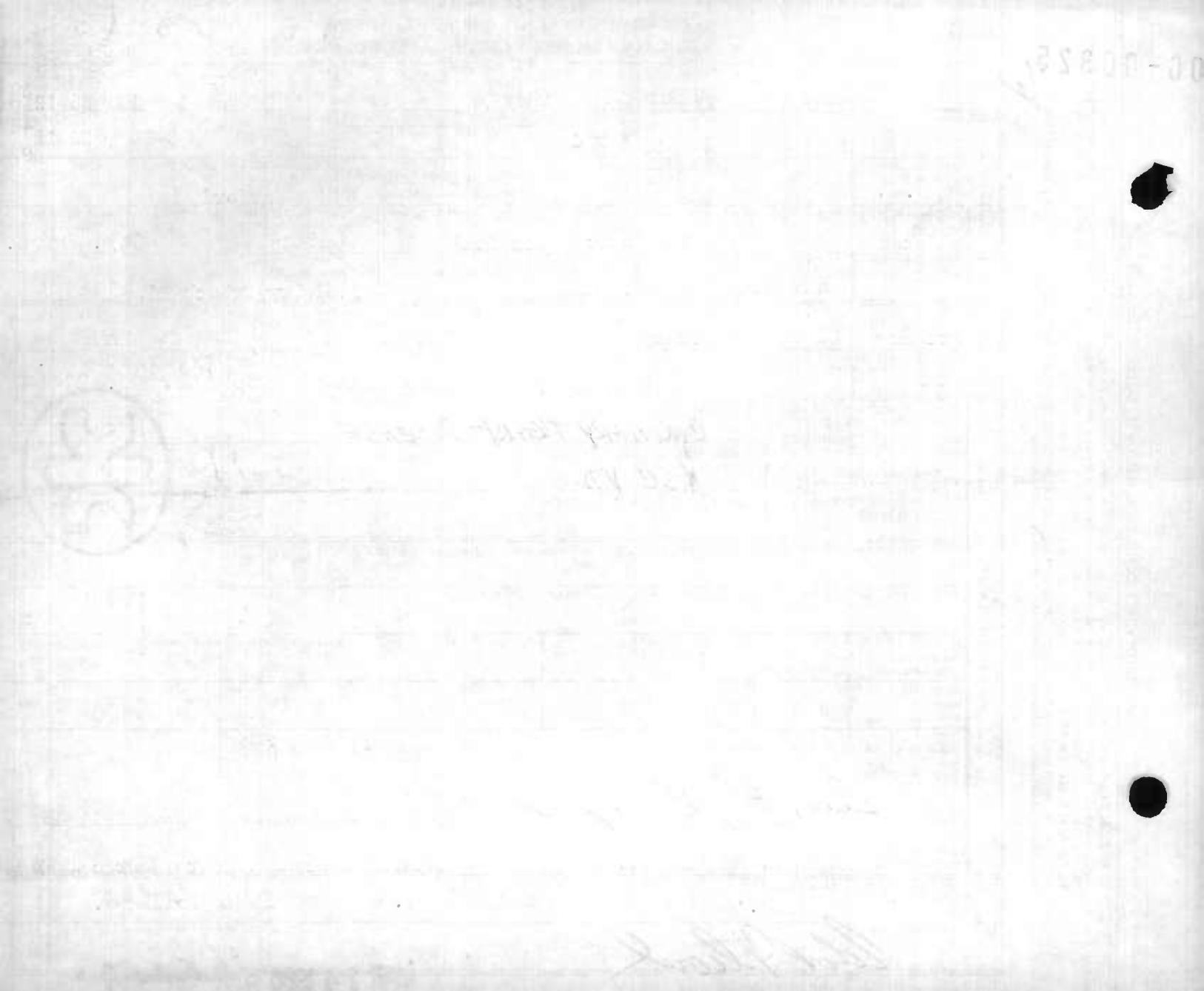
not at all

not the slightest bit (or person interviewed)

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM NO. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 0 8 5 8 5									
1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN EST. OF DEATH MATED <input checked="" type="checkbox"/> XX		MONTH 3	DAY 10	YEAR 1986	2b. HOUR 12 30 p.m.		
		Forney Ray Eller														MONTH 10	DAY 19	YEAR 86	2d. HOUR 12 40 p.m.		
3. SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR. MONTHS		IF UNDER 24 HRS. HOURS		MIN.		2c. DATE PRONOUNCED DEAD		2d. DATE RECD. BY REGISTRAR		2e. REGISTRAR'S SIGNATURE	
M		W		3 4 30			56 yrs.									3-10 1986					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford										
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor			12b. KIND OF BUSINESS OR INDUSTRY Cty. Govt.										
13a. STATE MD		13b. COUNTY Harford		13c. CITY OR TOWN White Hall			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 3401 Dry Branch Rd. 21161											
14. FATHER'S NAME FIRST Arthur		MIDDLE Forney			LAST			15. MOTHER'S MAIDEN NAME FIRST Lettie			16. ADDRESS 3401 Dry Branch Rd. Tammie Eller Whitehall, Md. 21161										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-28-9057			17. INFORMANT Tammie Eller			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause lost</u> . (b) <u>ASC.VD.</u> DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE									
22a. I certify that I took charge of the remains described above, held on <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE <i>Luis E. Renjel</i>		TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER									DATE SIGNED 3-11-86							
EXAMINER'S NAME (TYPE OR PRINT)		Luis E. Renjel M.D.			ADDRESS 464 Alliance St. Havre DeGrace, MD																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial Mar. 14 1986			23c. NAME OF CEMETERY OR CREMATORIAL Conowingo Bapt.			23d. LOCATION CITY OR TOWN Conowingo Ceil Md.			COUNTY		STATE								
24. FUNERAL DIRECTOR NAME		Grouch Funeral Home			ADDRESS North East,			Md.			25a. DATE REC'D. BY REGISTRAR MAR 14 1986		25b. REGISTRAR'S SIGNATURE <i>John Miller Jr.</i>								
BP		DHMH - 17 (VR A15 ME (5))																			

35-600325



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be resubmitted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 4 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as Item 18, show any injury, or other traumatic event. (If medical examiner will be called in, do not mark.)

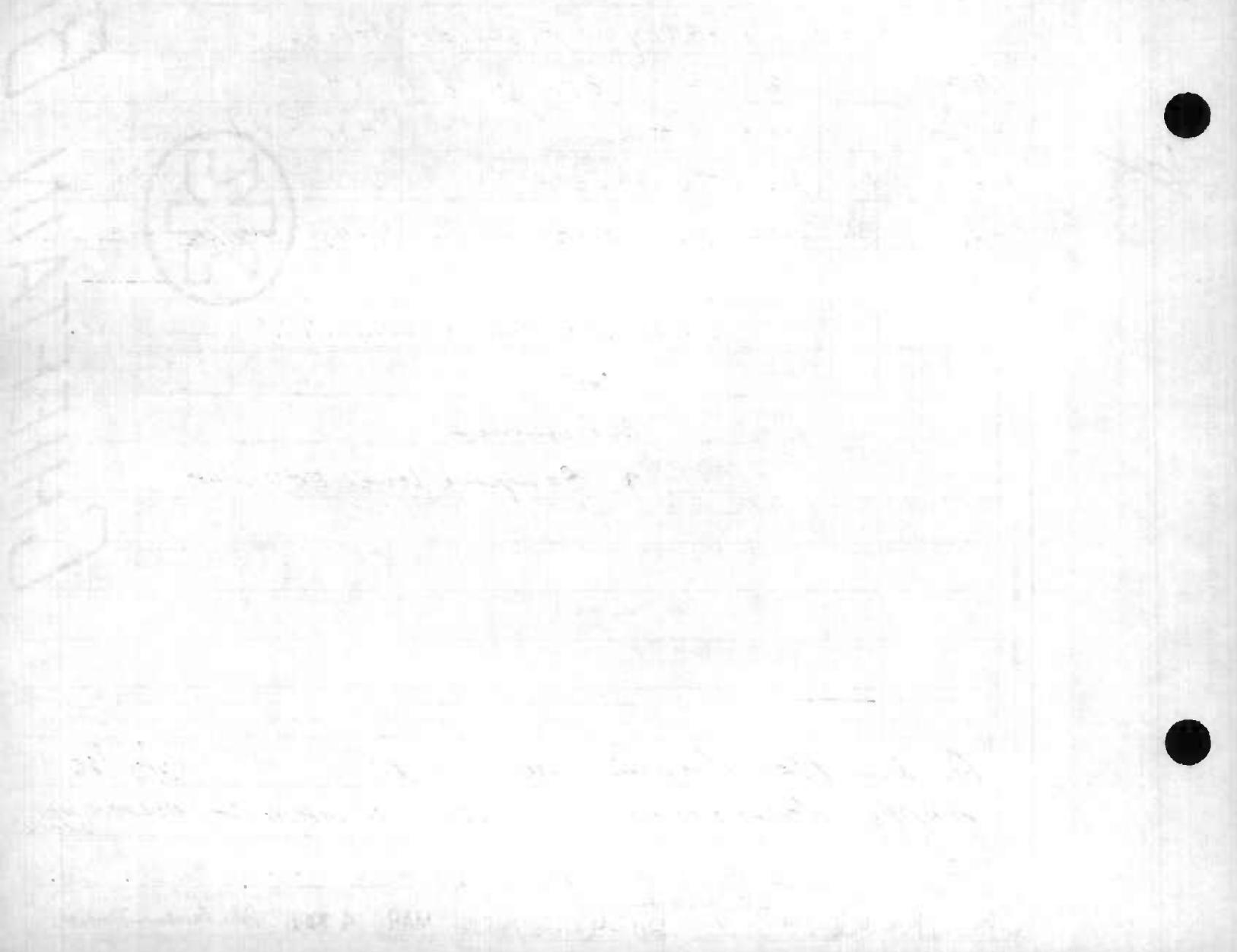
Frederick H. Fischer

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 0 8 5 8 0

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
FRED HENRY Fischer						3-1-86				11:30 P.M.	
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR			IF UNDER 24 HRS	
M/M		WHITE	MONTH	DAY	YEAR	84	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE COUNTRY		7b. STATE OR FOREIGN	7c. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland			AMERICA USA						Harford COUNTY		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
FAILSTON		FAILSTON GENERAL			CARPENTER			GOVERNMENT			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Md.		BALTIMORE		BALTIMORE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7875 OAKDALE AVE 21237			
14. FATHER'S NAME		MIDDLE	15. MOTHER'S MAIDEN NAME						MIDDLE	LAST	
AUGUST			ELIZABETH								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
NO		218 03 2791			VERNON FISCHER			7875 OAKDALE AVE.			
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHF											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia											
DUE TO, OR AS A CONSEQUENCE OF (c) Sanguine lower Extremities											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (1) We attended the deceased from _____, 19_____, to _____, 19_____, that (1) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DEGREE			ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED			
Andrew Nowakowski MD								3/3/86			
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS			125 N. MAIN ST BELAIR MD 21014						
ANDREW NOWAKOWSKI MD											
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 03/05/86		23c. NAME OF CEMETERY OR CREMATORIUM ZION CHURCH CEMETERY BALTO.			23d. LOCATION CITY OR TOWN		COUNTY	STATE	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Cecil Brudick f# 1014		121 Clifton A. St.		MAR 4 1986			Fischer Davidson Pendace				

OF 1000



00-01553

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial transit permit. Then please remove carbon paper and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, notify medical examiner.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
JOHN R FISHER, Sr						3	20	86	30	11 p.m.			
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR				
Male		White	MONTH	DAY	YEAR	49	48	YRS	MONTHS	DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Baltimore, Md.		U.S.A.						Harford County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
FALLSTON		FALLSTON GEN HosP			Car salesman			Self-Employed					
13a. STATE Maryland						13b. COUNTY Harford		13c. CITY OR TOWN Kingsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 808 Gary Ave. 21087	
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Edith M. Link		ADDRESS							
Alfred		James	Fisher			808 Gary Ave.							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 216-32-2428			17. INFORMANT Mrs. Florence C. Fisher, Kingsville, MD 21087								
no													
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS						TIME OF DEATH BETWEEN ONSET AND DEATH							
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						(b) LIVER FAILURE							
DUE TO, OR AS A CONSEQUENCE OF (c) METASTATIC BLADDER CA													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
DIABETES													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? LIMITED <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/28/86 to 3/20/86, that (we) last saw the deceased alive on 2/20/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) did not view the body after death.													
22b. SIGNATURE R. Phillips						DEGREE			22c. DATE SIGNED 3/2/86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. Phillips						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)						23b. DATE 3-24-1986			23c. NAME OF CEMETERY OR CREMATORIAL OAK Lawn Cemetery				
Burial									23d. LOCATION EASTPOINT BALTO. M.D.				
24. FUNERAL DIRECTOR NAME						ADDRESS 21887			25a. DATE REC'D. BY REGISTRAR MAR 26 1986				
E.F. LASAHN, 11750 BELAIR RD. KINGSVILLE, MD.									25b. REGISTRAR'S SIGNATURE Julia Davidson - Phillips				

00-01230

SD 85 RAM

00-01039

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86008588
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
		LEON	Gamber	Fulmer	3/7/86				10 26 PM		
3. SEX		4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)					
MALE		Caucasian	MONTH	DAY	YEAR	71	YRS				
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Pennsylvania		U.S.A.						HARFORD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
FAULSTON		FAULSTON GENERAL Hospital			Mechanic			Auto			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE		
MD		HARFORD		FOREST HILL		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			1821 CALDWELL MILL Rd 21050		
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			LAST			
		Edward	S.	Fulmer	Annie			Gamber			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
No		200-09-6637			Gerald L. Fulmer			same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Bilateral Pneumonia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Obstructive Airway Disease</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any: (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Arteriosclerotic Cardiovascular Disease</u>											
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3-7-1986 to 3-7-1986, that (I) (we) last saw the deceased alive on 3-7-1986, and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE <u>Kermit P. Bonovitch</u>		22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 3-10-86			
22e. PHYSICIAN'S NAME (TYPE OR PRINT)					22f. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL METHOD		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial		3/11/1986		East Petersburg Men. East Petersburg, Penna.							
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
M. Gladden Kurtz		Jarrettsville, Md.			MAR 13 1986			John Anderson - Rendell			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be retained for use on the burial permit. Then please remove carbon copies. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

REPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

20010-00

021000Z SEP 00

TELETYPE

RECORDED ON 021000Z SEP 00 BY SPC 100000Z SEP 00

Z

RECORDED ON 021000Z SEP 00 BY SPC 100000Z SEP 00

ITEMS 18-22a 3/21/86 mtb F#612 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0 6 0 8 5 8 9										REG. NO.		
DECEASED NAME FIRST MIDDLE LAST											2b HOUR	
DAVID G. GRAMS											MONTH DAY YEAR	
MALE WHITE JAN. 9, 1939 47 IF UNDER 1 YR. IF UNDER 24 HRS.											2d HOUR	
MONTH DAY MONTH DAYS HOURS MIN											MONTH DAY YEAR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND U. S. A. B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											2d HOUR	
10. CITY OR TOWN OF DEATH Fallston II. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital											12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE MARYLAND 13b. COUNTY HARFORD 13c. CITY OR TOWN EGEWOOD											12b. KIND OF BUSINESS OR INDUSTRY ARMCO STEEL 21040	
14. FATHER'S NAME SORVINO FIRST MIDDLE LAST GRAMS											15. MOTHER'S MAIDEN NAME FRANCES	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO 16b. SOCIAL SECURITY NO. 218 367 493											17. INFORMANT FAMILY RECORDS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20 AUTOPSY?	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.											DATE SIGNED 3-2-86	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3-5-1986			23c. NAME OF CEMETERY OR CREMATORIUM GARDENS OF FAITH			23d. LOCATION CITY OR TOWN ROSEDALE		COUNTY BALTO. MARYLAND STATE		
24 FUNERAL DIRECTOR NAME EVANS CHAPEL OF MEMORIES 8800		ADDRESS HARFORD ROAD			25a. DATE REC'D. BY REGISTRAR MAR 7 1986			25b. REGISTRAR'S SIGNATURE				

3110.10

A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

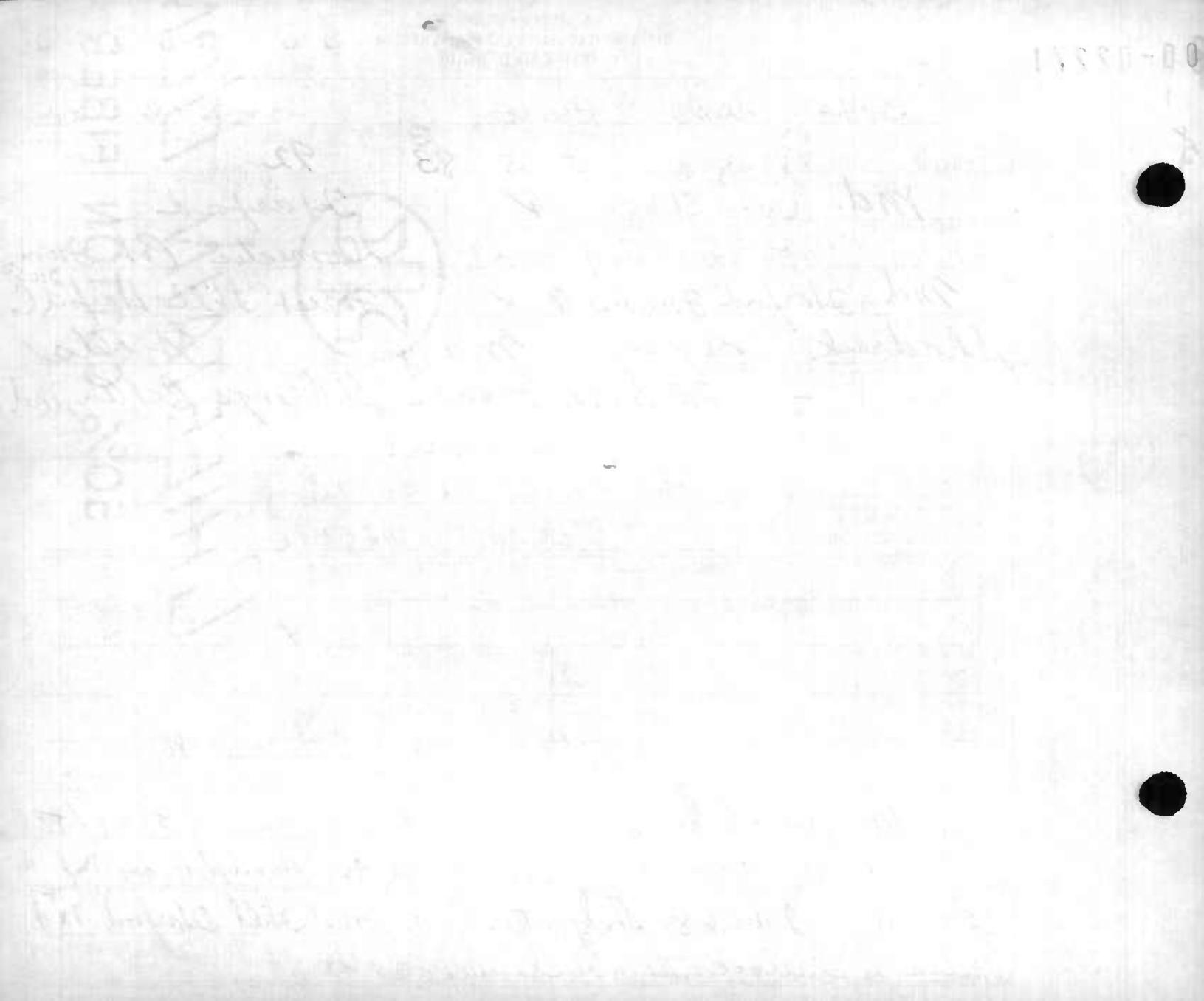
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove clip and send. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8608590				
										REG. NO.				
1. DECEASED NAME [TYPE OR PRINT]			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Bertha Doesey					BRENE	3-22-86					1986	2:20 PM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
Female		Black		5 5 88			92 YRS.							
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OR WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Md.		United States					Harford							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION [TYPE OF WORK FOR MOST OF WORKING LIFE]				
Fallston		Fallston General Hospital								Domestic				
13a. STATE 13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			12b. KIND OF BUSINESS OR INDUSTRY				
Md		Harford		Forest Hill			Forest Hill - Harford C. 21050							
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST						LAST				
Shadrack		Doesey		Mary						Wells				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No		- 213-28-1961		Frances G. Orange - Bel Air, Md.										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST														
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
DUE TO, OR AS A CONSEQUENCE OF (c) HEMI-T DISEASE														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED [ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2]			19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (1) (this hospital) attended the deceased from 3/22/86 to 3/22/86, that (1) (we) last saw the deceased alive on 3/22/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.														
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED							
Dante N. Monksil							3/24/86							
22d. PHYSICIAN'S NAME [TYPE OR PRINT]		22e. ADDRESS												
DANTE N. MONSKIL		622 Union Ave Arnold Grace Md												
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S NAME			
Burial		Mar. 26-86		St. Ignatius Cem.			Forest Hill Harford, Md.		1986		Julie Danter			
24. FUNERAL DIRECTOR NAME		ADDRESS												
Otelia J. Bullock - Harde Grace, Md.														

1938-00



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONE, WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR Cremation.

MEDICAL CERTIFICATION

1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH08591
REG. NO.

I. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Bertha</i>	MIDDLE <i>Mae</i>	LAST <i>Handy</i>	2a. DATE KNOWN OF ESTI. DEATH MATED	MONTH 3	DAY 14	YEAR 1986	2b. HOUR 6 AM
1. SEX	4. RACE	5. DATE OF BIRTH MONTH <i>6</i>	DAY <i>23</i>	YEAR <i>26</i>	6. AGE IN YEARS LAST BIRTHDAY	IF UNDER 1 YR. MONTHS <i>59</i>	IF UNDER 24 HRS. DAYS <i>YRS.</i>	HOURS <i></i>	MIN <i></i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		2c. DATE PRONOUNCED DEAD		9. BALTIMORE CITY OR COUNTY OF DEATH	
<i>Baltimore</i>		<i>USA</i>		<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		<i>3-14-86</i>		<i>Harrowd</i>	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK)		12b. KIND OF BUSINESS OR INDUSTRY			
<i>Joppa</i>		<i>542 Anchor Dr.</i>		<i>Computer Programmer</i>		<i>Retired</i>		<i>Electronics</i>	
13a. STATE <i>MD</i>		13b. COUNTY <i>Hanover</i>		13c. CITY OR TOWN <i>Joppa</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>542 Anchor Dr. Joppa</i>	
14. FATHER'S NAME FIRST <i>Maurice</i>		MIDDLE <i>Howard</i>		LAST <i>Brown</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Louise</i>		LAST <i>Rosmark</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>216-20-7245</i>		16c. INFORMANT <i>Clairene Henney (Hargrave)</i>		ADDRESS <i>542 Anchor Drive, Joppatown, Md. 21085</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____									
Cirrhosis of liver. alcoholism - Hypertension									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Louis E Reycer</i>		TITLE (SPECIFY) M.D. <i>Deputy</i>		MEDICAL EXAMINER		DATE SIGNED <i>3-14-86</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>Louis E Reycer</i>		ADDRESS <i>464 Allaire St. Havre de Grace, Md. 21044</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>Mar. 16, 1986</i>		23c. NAME OF CEMETERY OR CREMATORY <i>R.A. Ferris Crematory</i>		23d. LOCATION CITY OR TOWN <i>W. Chester</i>		COUNTY STATE <i>Chester Pa.</i>	
24. FUNERAL DIRECTOR NAME <i>Howard K. McComas III</i>		ADDRESS <i>Abingdon, Md. 21009</i>		25a. DATE REC'D. BY REGISTRAR <i>MAR 17 1986</i>		25b. REGISTRAR'S SIGNATURE <i>John Pendle</i>			
(VR A15 ME (5))									

20% COTTON



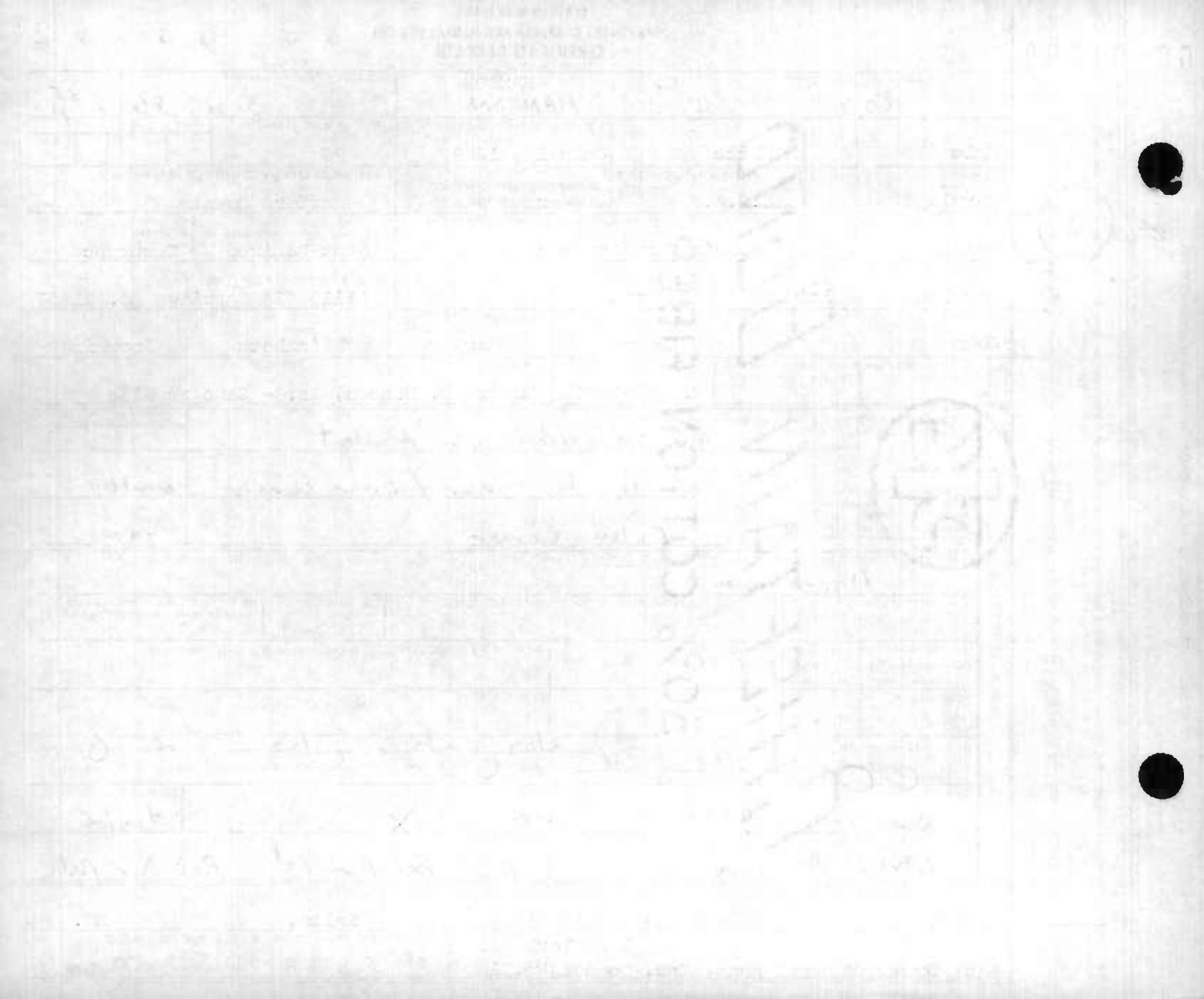
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, file the funeral director, page 3 should be detached for use on the burial certificate. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as being "alive" item 18 shows any injury, or other traumatic event, the medical examiner on the death certificate must be informed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8608592	
1. DECEASED NAME (TYPE OR PRINT)		FIRST ROY	MIDDLE C.	LAST HANSON	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Roy		C.		HANSON	3	29	86	6 55 p.m.			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
Male		White		Month July 15, 1889 Year			96 YRS.		IF UNDER 12 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Maryland		U.S.A.					Harford County				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Belair		Belair Nursing Home		Agent-Retired			Insurance				
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Glen Arm.			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 11113 Old Carriage Rd. 21057		
14. FATHER'S NAME FIRST John		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST Mary			MIDDLE	LAST	Elizabeth Browning		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. No 214-03-3002		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for 10, 11, and 15) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) Massive Cerebrovascular Accident											
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Cancer / Liver cancer month											
DUE TO, OR AS A CONSEQUENCE OF (c) Colon Cancer years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11o Hypertension											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED HOME <input type="checkbox"/> IN OFFICE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 2/24/86 to 3/19/86, that (we) lost saw the deceased alive on 3/18/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not) view the body after death.											
22b. SIGNATURE David McClure		22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 3/29/86			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID McClure		22f. ADDRESS 1131 Bel Air Rd Bel Air, MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-2-86		23c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge			23d. LOCATION CITY OR TOWN Balto.		COUNTY		STATE Md.
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.		ADDRESS 1050 York Rd. Towson, Md. 21204			25a. DATE REC'D. BY REGISTRAR APR 01 1986			25b. REGISTRAR'S SIGNATURE S. Linda Neidam Pandore			
DHMH - 16 60M 7-84 (VRA 15, 4)											



DIVISION OF VITAL RECORDS 2011 MIGRATION DATA

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENSION ITEM 3B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL CERTIFICATE. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO

0 8 5 9 3

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR		
ANGELA F.			HENDERSON			<input checked="" type="checkbox"/>						
3. SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d HOUR		
Female	white	2 12 1934				<input type="checkbox"/>	3	24	1986	10:30 P.M.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Balto. Co. Md.		U. S. a.					Harford County			MD		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY				
Fallston		Fallston General Hospital			House wife			Home Keeping				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STATE Maryland						
						13b. COUNTY Harford						
						13c. CITY OR TOWN Fallston						
						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 3338 Charles St. 21047					
						13f. MOTHER'S MAIDEN NAME Frances Perri						
14. FATHER'S NAME FIRST Antonio MIDDLE Dattoli LAST						17. INFORMANT Mr. Waring A. Henderson, Fallston, Md. 21047						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO. 214-30-4601						
						ADDRESS 3338 Charles St.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease												
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.						DUE TO, OR AS A CONSEQUENCE OF						
(b) _____												
DUE TO, OR AS A CONSEQUENCE OF												
(c) _____												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?	
											YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY P.M. HOUR A.M. MONTH DAY YEAR			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
			P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER												
DATE SIGNED 3-26-86												
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 111 Penn St., Balto., MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL Highview Mem. Gardens			23d. LOCATION CITY OR TOWN Fallston		COUNTY Harford STATE Md.		
Burial			3-28-1986									
24. FUNERAL DIRECTOR NAME ADDRESS												
E.F.Lassahn, 11750 Belair Rd. Kingsville, Md. 21087 APR 1 - 1986 John Lassahn, Esquire												
25a. DATE REC'D. BY REGISTRAR												
25b. REGISTRAR'S SIGNATURE												

1550-00

1550-00
1550-00

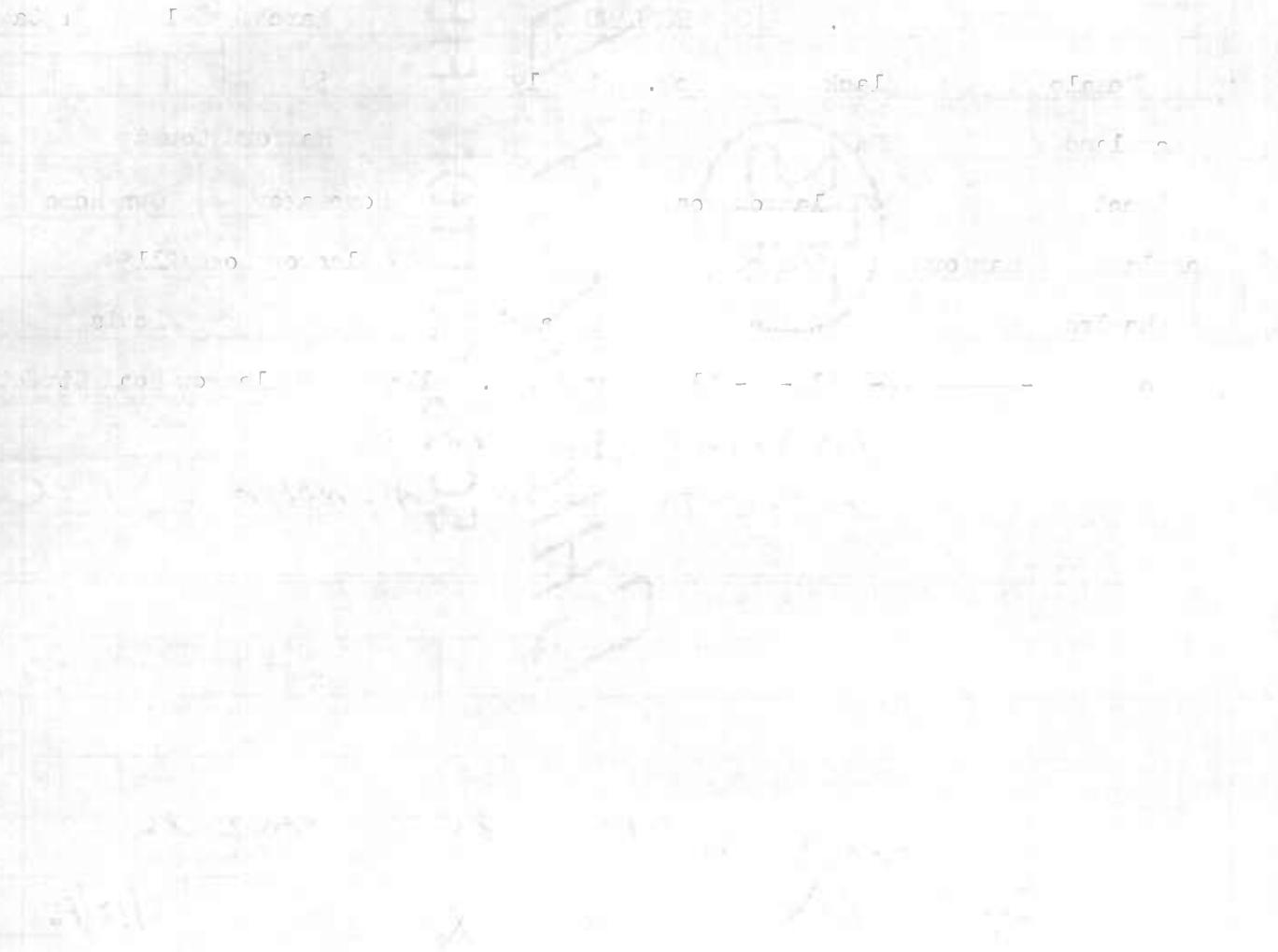
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached from the front panel and then placed in carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be informed at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 6 0 8 5 9 4					
												REG. NO.					
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
			EVELYN R. HOLLAND						March	8	1986		3:30am				
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
Female			Black			Feb. 2 1928			58 yrs.								
7. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Maryland			USA						Harford County								
10. CITY OR TOWN OF DEATH Street			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
			447 Glasgow Road			Homemaker			Own Home								
13a. STATE Maryland			13b. COUNTY Harford			13c. CITY OR TOWN Street			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 447 Glasgow Road/21154					
14. FATHER'S NAME FIRST Charles			MIDDLE			LAST Akins			15. MOTHER'S MAIDEN NAME FIRST Mabel			MIDDLE			LAST Lewis		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)			16b. SOCIAL SECURITY NO. No			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
			216-24-3214			Charles H. Holland			447 Glasgow Road Street, MD								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u>																	
DOUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC COLON CARCINOMA</u>												14R					
DOUE TO, OR AS A CONSEQUENCE OF (c) _____																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED <small>AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/></small>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT 19 85</u> to <u>MAR 7 1986</u> , that (I) (we) last saw the deceased alive on <u>MAR 7 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.																	
22b. SIGNATURE <u>Gary I. Cohen</u>			22c. DEGREE <u>M.D.</u>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <u>3/18/86</u>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			711 West 40th. Street Baltimore, MD											
Gary I. Cohen, M.D.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 3/13/86			23c. NAME OF CEMETERY OR CREMATORIAL Chestnut Grove Cemetery			23d. LOCATION CITY OR TOWN Harford			COUNTY	STATE				
24. FUNERAL DIRECTOR NAME John Harkins			ADDRESS 600 Main Street Delta, PA 17314			25a. DATE REC'D. BY REGISTRAR MAR 26 1986			25b. REGISTRAR'S SIGNATURE <u>Suzanne Rendell</u>								

1320-00



Mr. John G. Edwards, 1900-1901

President, Western New England College

1939-1940, 1941-1942, 1943-1944

00-00011

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM B. GIVE PAGES 1 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3 WHICH SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD NOT BE USED AS A BURIAL TRANSIT PERMIT. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 08595		
1- FOR STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE KNOWN OF ESTI- DEATH MATED			2b. MONTH DAY YEAR		
			William W. House Jr.						<input checked="" type="checkbox"/>			3-10 1866		
3- SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2d. HOUR MONTH DAY YEAR		
MALE		WHITE		FEB. 26, 1911		75 yrs.						2d. HOUR 30 12p.m.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND			USA						HARFORD COUNTY					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY					
DARLINGTON			2106 GLEN COVE ROAD						(RET) ASST. OPERATOR			POWER PLANT		
13a. STATE MO			13b. COUNTY HARFORD		13c. CITY OR TOWN DARLINGTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2106 GLEN COVE ROAD			21034		
14 FATHER'S NAME FIRST WILLIAM			MIDDLE WALTER		LAST HOUSE, SR.		15. MOTHER'S MAIDEN NAME FIRST BESS		LAST L.			SCARBOROUGH		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 216 16 7730			17. INFORMANT MRS. RUTH IRMA HOUSE,			ADDRESS SAME AS #13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary heart disease</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause</u> lost. (b) <i>ASCD</i>														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?								
						<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>Luis E. Renjel</i>		TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER			DATE SIGNED 3-10-86						
EXAMINER'S NAME (TYPE OR PRINT)			Luis E. Renjel, M.D.			ADDRESS 464 Alliance St. Havre De Grace, MD								
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN COUNTY STATE							
BURIAL		13 MARCH 86		DARLINGTON CEMETERY			DARLINGTON, HARFORD CO., MARYLAND							
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MO. 21078						MAR 12 1986			<i>Jane Anderson</i>					
07/84 25M BP		DHMH - 17 (VR A15 ME (5))												

11000-00



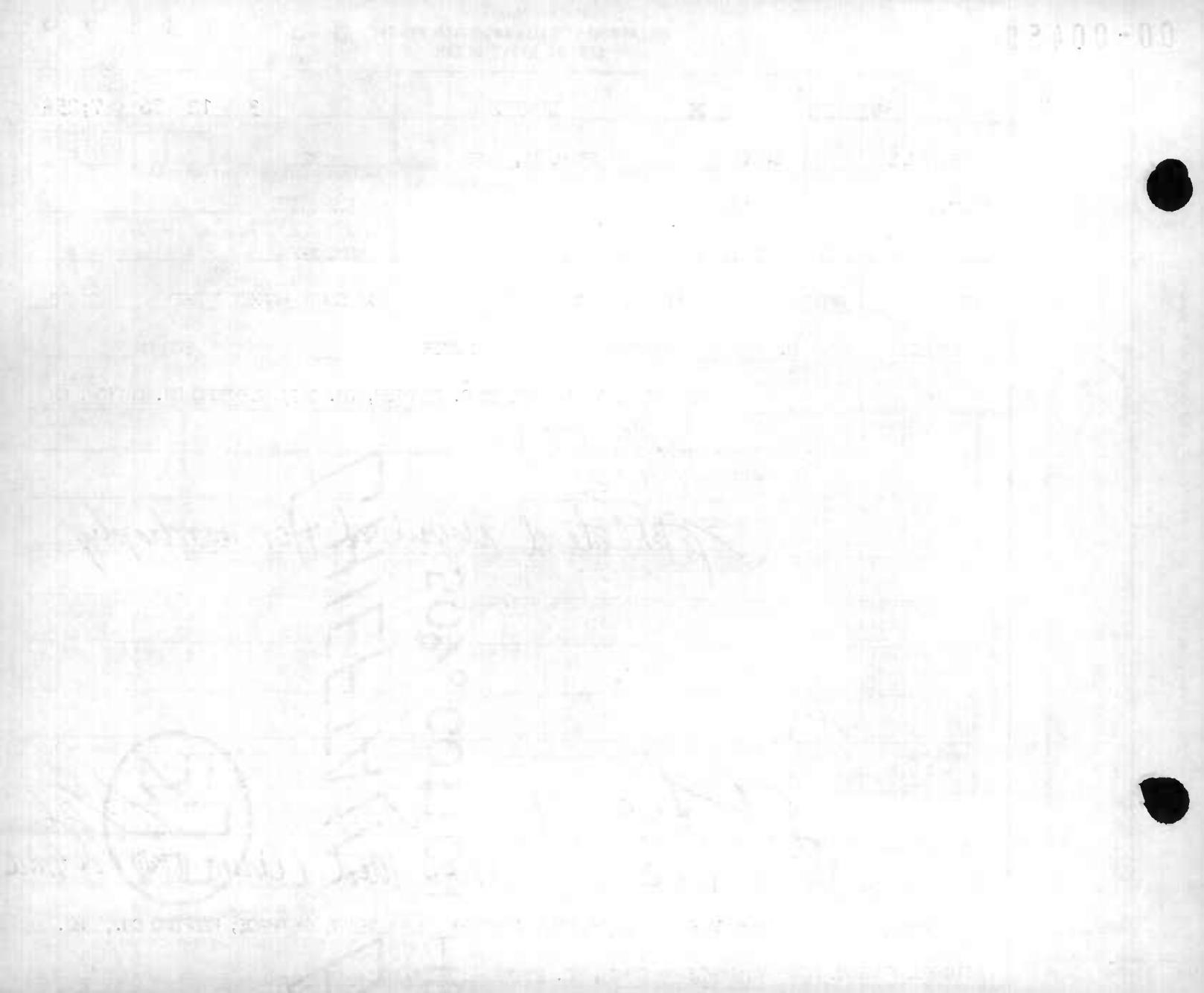
00-004501

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 8 5 9 6

REG. NO.

1. DECEASED NAME VIRLIE HUGHES			2a. DATE OF DEATH 3 12 86	MONTH DAY YEAR	2b. HOUR 7:25 AM	
3. SEX FEMALE		4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR APRIL 11, 1893	6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.		
10. CITY OR TOWN OF DEATH HAVRE DE GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITIZENS NURSING HOME			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	
13a. STATE MD		13b. COUNTY HARFORD	13c. CITY OR TOWN HAVRE de GRACE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 415 SOUTH MARKET STREET 21078	
14. FATHER'S NAME FIRST WILLIAM		MIDDLE H.	LAST DEPPISH	15. MOTHER'S MAIDEN NAME FIRST CARRIE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220 D2 7943		17. INFORMANT ADDRESS WALTER C. DEPPISH, JR. 2431 GLENBORO DR. DAYTON, OH 45431		
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HAB COP Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CBS (c) State of Virgilian Hernorrhaphy						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOT BY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED. (ENTER NATURE OF INJURY IN ITEM 19, PART I OR PART II)			
22a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	22c. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22d. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (II) (we) last saw the deceased alive on _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22e. SIGNATURE J. T. Lee		22f. DEGREE M.D.	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22g. DATE SIGNED 3/28/86		
22h. PHYSICIAN'S NAME (PRINT) J. T. Lee		22i. ADDRESS Union Med. Clinic, Havre de Grace				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 14MARCH86	23c. NAME OF CEMETERY OR CREMATORIUM ANGEL HILL CEMETERY	23d. LOCATION CITY OR TOWN HAVRE de GRACE, HARFORD CO., MD.	25a. DATE REC'D. BY REGISTRAR MAR 17 1986	25b. REGISTRAR'S SIGNATURE J. T. Lee
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA		ADDRESS HAVRE de GRACE, MD. 21078				
DHMH - 16 50M 4/83 (VRA 15, 4)						

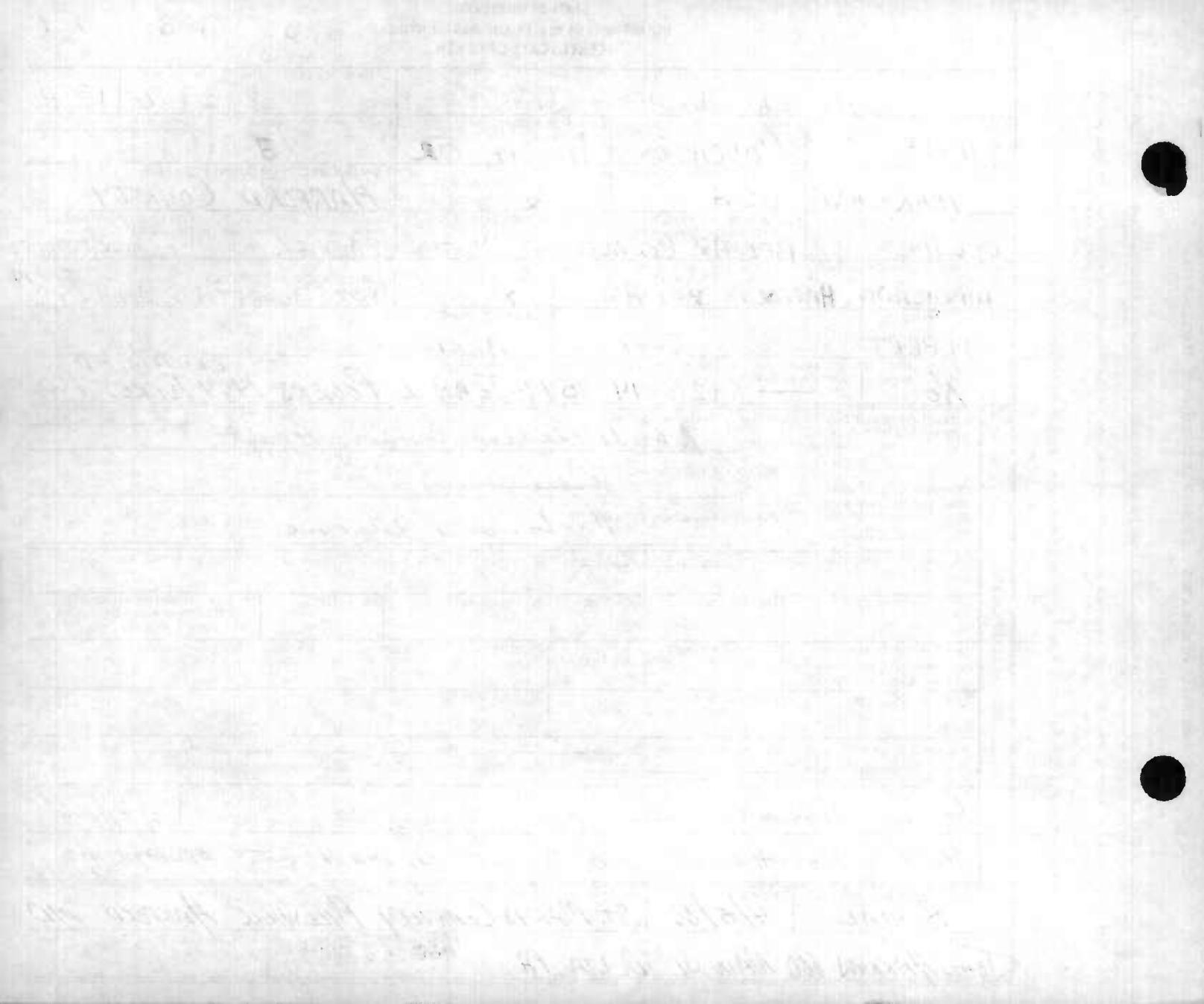


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8608597			
												REG. NO.			
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			Samuel HOWARD JENKINS						3 29 86			130 P.M.			
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE			CAUCASION			12 14 02			83 YRS.			MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
MARYLAND			USA						HARFORD COUNTY						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			SOUTHERN STATES			
BEL Air			BEL AIR CONVALESCENT CENTER			FARMER						21014			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13e. STREET ADDRESS / ZIP CODE			
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1320 TURRET RD. BEL AIR, MD.			
MARYLAND			HARFORD			BEL AIR									
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
ALBERT			ANNIE			No			218-14-8579			JEAN L. POWERS BEL AIR, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												(b) Pneumonia			
{ DUE TO, OR AS A CONSEQUENCE OF (c) Parkinson's Disease															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Andrew Nowakowski, MD			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 3/3/86						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW NOWAKOWSKI, MD			22f. ADDRESS 125 N. MAIN ST. BEL AIR, MD 21014												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/5/86			23c. NAME OF CEMETERY OR CREMATORIAL ST. MARY'S CEMETERY			23d. LOCATION CITY OR TOWN PYLESVILLE COUNTY HARFORD STATE MD			23e. DATE REC'D. BY REGISTRAR 1986 23f. REGISTRAR'S SIGNATURE John Harkins, Delta, PA			
24. FUNERAL DIRECTOR NAME John Harkins 600 Main St. Delta, PA			ADDRESS												



00-0155

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8008598
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
Clara			m.		Jones	March 21 1986				6:30 p.m.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Female		White		MONTH Oct.	DAY 19	YEAR 1908	77 yrs						
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				MD.			
Pennsylvania		USA				Harford							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Havre de Grace			Harford Memorial Hospital						Homemaker			Own Home	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
Maryland		Harford		Whiteford		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1520 Ridge Road/21160					
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST	Moore			
Amer				Founds	Henrietta								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No			219-72-9620			Robert A. Jones, Jr. P.O.Box 181 Delta, PA							
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL B/W ONSET AND DEATH	
<p>Cardiorespiratory arrest</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>Congestive heart failure</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>Renal failure</p> <p>(c) Severe bowel disease</p>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART Ia													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
									<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)							
21d. INJURY OCCURRED <input type="checkbox"/> WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22. I certify that (I/this hospital) attended the deceased from Nov. 27, 1985, to March 21, 1986, that (I/we) last saw the deceased alive on March 21, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did not see the body after death.													
23. SIGNATURE													
DEGREE													
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>													
24. FUNDAMENTAL'S NAME (TYPE OR PRINT)													
25. ADDRESS													
26. BURIAL, CREMATION, REMOVAL (SPECIFY)			27. DATE			28. NAME OF CEMETERY OR CREMATORIUM			29. LOCATION CITY OR TOWN				
Burial			3/25/86			Slate Ridge Cemetery			Peachbottom Twp., York, PA				
NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
John Harkins			600 Main Street Delta, PA 17314			MAR 26 1986			John Harkins				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remember to return the entire paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury or other findings, the medical examiner must be called.

12210-00

PROBLEMS

00-00237

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8608599

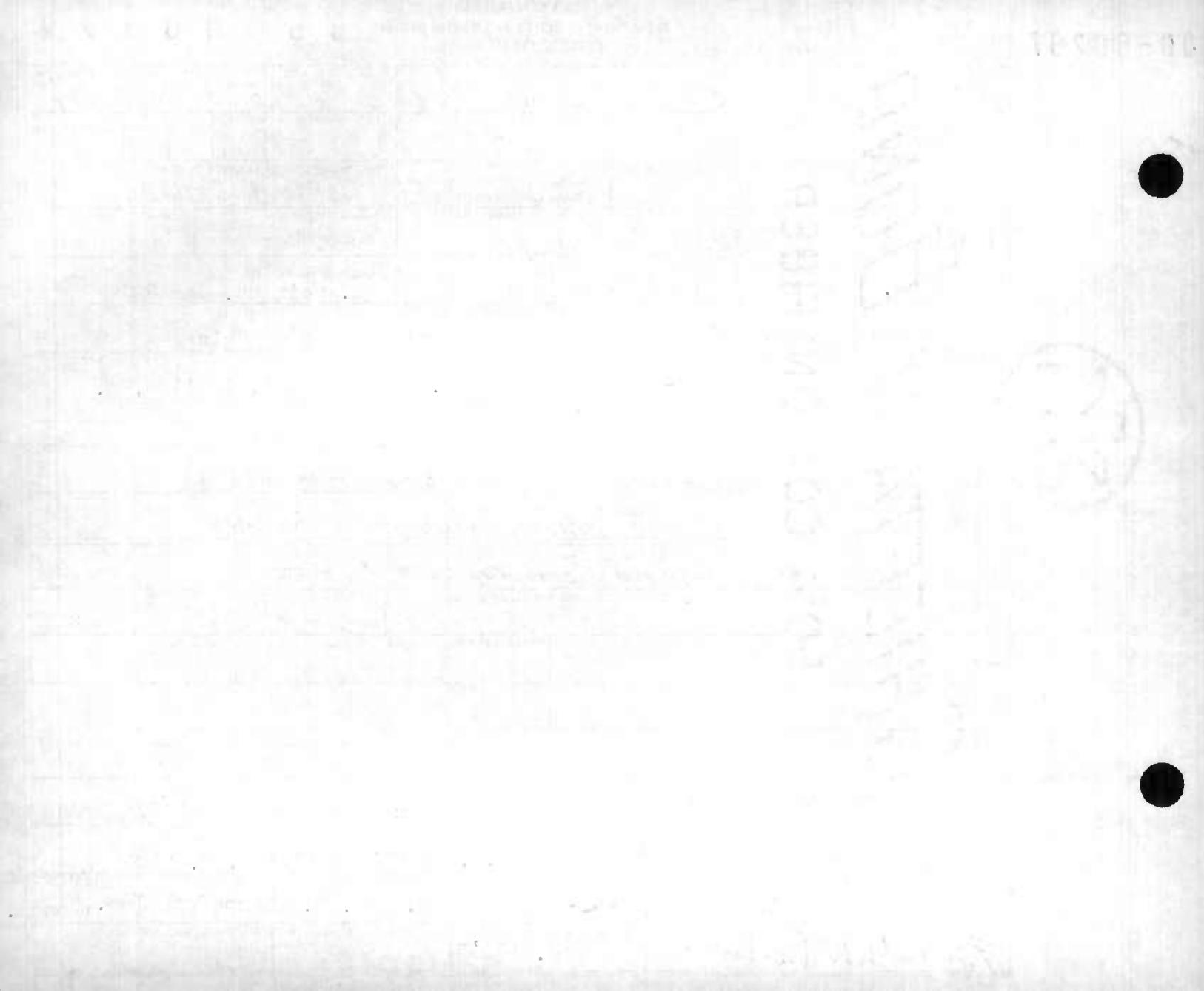
REG. NO.

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it should be given to the funeral director. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours after death.
 IMPORTANT: If item 2 is marked as having been signed, any injury, or other information concerning the deceased should be attached for use as the burial permit. Then please remove carbon copy.
 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1. FOR STATE REGISTRAR												
11. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Myrtle</i>	MIDDLE <i>C</i>	LAST <i>Jones</i>	20. DATE OF DEATH MONTH <i>01</i>	MONTH <i>04</i>	DAY <i>86</i>	YEAR <i>79</i>	2b HOUR <i>7 43</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH <i>01</i>		YEAR <i>27/87</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>79</i> YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE COUNTRY <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Hanford County</i>						
10. CITY OR TOWN OF DEATH <i>Fallston</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Fallston Gen Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>						
13a. STATE <i>Penna.</i>		13b. COUNTY <i>York</i>		13c. CITY OR TOWN <i>Fawn Grove</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>S. Main St. Box 76</i>		13f. ADDRESS <i>99999</i>		
14. FATHER'S NAME FIRST <i>Samuel</i>		MIDDLE <i>John</i>	LAST <i>Thompson</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Carrie</i>		MIDDLE <i>Mae</i>	LAST <i>Pyle</i>	16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		18. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <i>178-16-2793</i>		17. INFORMANT <i>Sandy L. Boules</i>		19. ADDRESS <i>RD#1, Airville, Pa. 17302</i>						
18. CAUSE OF DEATH: Enter only one cause per line for 10, 1b, and c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIO RESPIRATORY ARREST</i>												
DUE TO, OR AS A CONSEQUENCE OF (b) <i>ACUTE RESPIRATORY FAILURE</i>												
DUE TO, OR AS A CONSEQUENCE OF (c) <i>SEVERE OBSTRUCTIVE LUNG DISEASE</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 o <i>EMPHYSEMA / ASTHMA / MALNUTRITION, AGED</i>												
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												
22b. SIGNATURE <i>Luis F Sanchez</i>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <i>3/4/1986</i>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Luis F Sanchez</i>		22f. ADDRESS <i>P.O. Box 491 Fallston, Md. 21047</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3/8/86</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Chancery Presby.</i>		23d. LOCATION CITY OR TOWN <i>Dem. L. Chancery Twp., Penna.</i>		23e. COUNTY <i>York Co.</i>		23f. STATE <i>Penn.</i>		
24. FUNERAL DIRECTOR NAME <i>Kenneth W. Coburn</i>		25a. ADDRESS <i>Stewartstown Penna. 17363</i>		25b. DATE REC'D. BY REGISTRAR <i>MR 10 1986</i>		25c. REGISTRAR'S SIGNATURE <i>K. Coburn</i>						

999999

BP



00-00994

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8608600

REG. NO.

1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>Nelson Edward</i>					<i>Kalmbacher</i>	<i>March 17, 1986</i>				<i>1240 P</i>	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Male		White		May 30, 1913		72 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
<i>Maryland</i>		<i>U.S.A.</i>				<i>Harford</i>					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
<i>Harford Grace</i>		<i>Harford Memorial Hosp</i>		<i>Cabinet Maker</i>		<i>US Gov't.</i>					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland		Harford		Aberdeen				1328 Stepney Road/21001			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
<i>Alexander</i>				<i>Kalmbacher</i>		<i>Mary</i>				<i>Keithley</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS		21001			
NO		N/A		215-03-6620		<i>Donna Kalmbacher, 1328 Stepney RD, Aberdeen, MD</i>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory Arrest</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Renal Failure</i>) About 1 year											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Calyxes</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Chronic Obstructive Pulmonary Disease</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>7/85</i> , to <i>3/17</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>3/17</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <i>mm lynn</i> DEGREE											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22f. DATE SIGNED <i>3/17/86</i>					
<i>Lynn, Franca</i>		<i>8 Law St Box 578 Aberdeen, MD 21001</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		Mar. 21, 1986		Baker Cemetery		Aberdeen		Harford		Maryland	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
<i>Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399</i>				<i>MAR 20 1986</i>		<i>Signature</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and delivered to you, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 3 and 4 may be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

BP _____

JR 200-00

RECEIVED
LIBRARY OF CONGRESS
2000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or the burial permit, then please forward to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as being shown to the deceased, or if item 22 is marked as being shown to the attending physician, then the certificate must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8608601	
1 - STATE REGISTRAR			2d. DATE OF DEATH MONTH DAY YEAR							2b. HOUR 50	
1. DECEASED NAME (TYPE OR PRINT) Gladys			MIDDLE Adelaide		LAST Kahr			, March 19, 1986		12 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH May DAY 28 YEAR 1908			6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7. BIRTHPLACE STATE OR FOREIGN COMBINED Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Hartford, MD.				
10. CITY OR TOWN OF DEATH Ellicott		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hosp.		12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12c. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Maryland		13b. COUNTY A A Co.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 503 Greenway S.E. 21061			
14. FATHER'S NAME Roy		FIRST MIDDLE C. LAST Sigler		15. MOTHER'S MAIDEN NAME Mamie		16. SOCIAL SECURITY NO. 112-34-3464		17. INFORMANT (Daughter) Mrs. Doris A. Cashen		ADDRESS 7 Second Ave. S. Ferndale 21061 Glen Burnie, Md.	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		18b. IMMEDIATE CAUSE (a) PART I. DEATH WAS CAUSED BY		18c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12:50 pm 3/19/86							
		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first		{ (b) End stage Rheumatic heart disease with						years	
				{ (c) Recent Viral Pneumonia						3 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (if this hospital) attended the deceased from Feb. 16, 1986, to Mar. 19, 1986, that (if we last saw the deceased alive on May 19, 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (if we did) did not view the body after death.)											
22b. SIGNATURE Albert S.C. Sun. M.D.		22c. DEGREE 879-3220			ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			DATE SIGNED 3/19/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert S.C. Sun. M.D.		22e. ADDRESS 1800 Harford Rd., Fallston 21047									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 22, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Mem. Park			23d. LOCATION CITY OR TOWN Glen Burnie COUNTY A A Co. STATE MD.				
24. FUNERAL DIRECTOR NAME R. D. Hopkins		ADDRESS Singleton Funeral Home			25a. DATE REC'D. BY REGISTRAR MAR 24 1986			25b. REGISTRAR'S SIGNATURE Julie Davidson Pendleton			
		Glen Burnie, Md.									

EDUCATION (Indicate only highest grade completed)

12 College (1-4 or 5-1)

20b

ACTING THE PREGNANCY (Describe as "now")

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0 3 6 0 2

J - 007137

REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-3, SEPARATE PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL OR CREMATION, OR REMOVAL

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

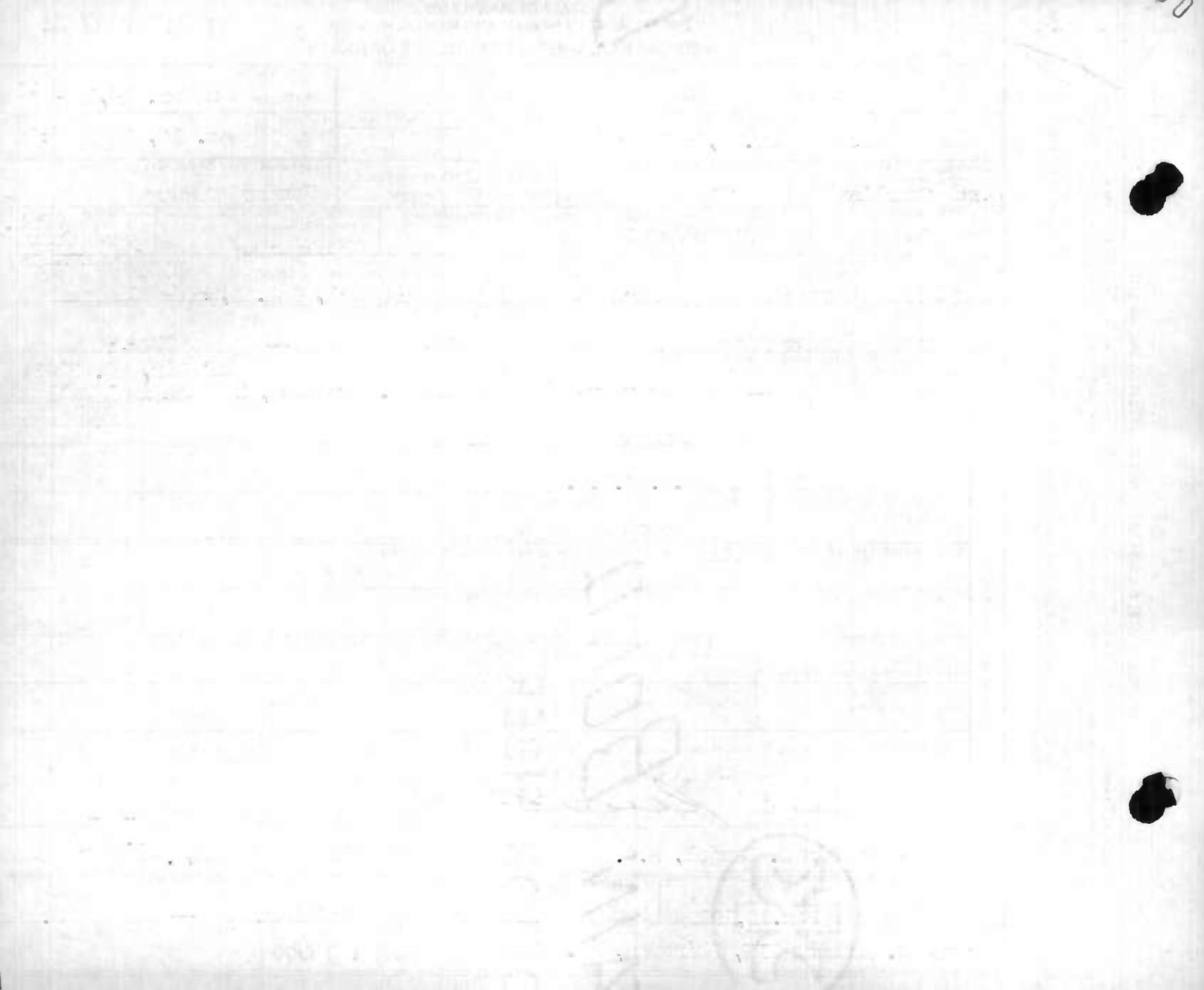
MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR OF ESTI. DEATH MATED <input checked="" type="checkbox"/> Mar. 16, 1986 11 AM	2b. HOUR	
JAMES ABNER LADD								
2c. SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Mar. 16, 1986 6:15 PM	2d. HOUR	
Male	White	Nov. 28, 1911						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County		
North Carolina		USA						
10. CITY OR TOWN OF DEATH Abingdon		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3631 Woodsdale Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		
13a. STATE Maryland		13b. COUNTY Harford	13c. CITY OR TOWN Abingdon	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3631, Apt. A, Woodsdale Road	12b. KIND OF BUSINESS OR INDUSTRY Coast Guard Electronics	
14. FATHER'S NAME FIRST George		MIDDLE Washington	LAST Ladd	15. MOTHER'S MAIDEN NAME FIRST Olive		Keaton		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 245-09-3501		17. INFORMANT Rebecca J. Thompson, 2405 Medical Hall Rd		ADDRESS Bel Air, Md. 21014		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>A.S. C.V.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes</u>								
19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21c. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21d. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21e. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21f. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21g. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21h. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Luis E. Renjel</i>		TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER						
EXAMINER'S NAME (TYPE OR PRINT) Luis E. Renjel, M.D.		ADDRESS 464 Alliance Street, Havre de Grace						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 19, 1986		23c. NAME OF CEMETERY OR CREMATORIUM Parkwood Cemetery		23d. LOCATION CITY OR TOWN Baltimore		
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009						25a. DATE REC'D. BY REGISTRAR MAR 19 1986		
						25b. REGISTRAR'S SIGNATURE <i>Howard K. McComas III</i>		

BP _____
DHHM - 17
(VR A15 ME (5))
20M 4/B2

DATE SIGNED
3-16-86

Me. 21078



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked **acutem** shows injury, or other traumatic event, it is listed on item 20.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8608603		
1 - STATE REGISTRAR		2a. DATE OF DEATH 3 20 86 MONTH DAY YEAR										2b. HOUR 9:10 AM
1. DECEASED NAME (TYPE OR PRINT)		FIRST HANNAH MIDDLE B.	LAST LANDWEHR									
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH September DAY 7 YEAR 1902		6. AGE (IN YEARS LAST BIRTHDAY) 83		IF UNDER 1 YEAR MONTHS 0 DAYS 0		# IF UNDER 24 HRS HOURS 0 MIN. 0		
7a. BIRTHPLACE COUNTRY Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD County MD.						
10. CITY OR TOWN OF DEATH BAVRE DE GRACE		NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITIZENS NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired School Teacher-Education		12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10188 Route # 99		13f. ZIP CODE 21043		
14. FATHER'S NAME Henry		14b. MIDDLE Broadbelt		15. MOTHER'S MAIDEN NAME Berti M. (Unknown)								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES OR UNKNOWN No		16b. SOCIAL SECURITY NO. 214-40-3021		17. INFORMANT Louis Franck		18. PLACE OF DEATH 347 Town Green Way Reisterstown, MD. 21136						
18. CAUSE OF DEATH: Enter only one cause per line for item 18. Part I PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE: Acute myocardial infarction												
DUE TO, OR AS A CONSEQUENCE OF: ASACD												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												
DUE TO, OR AS A CONSEQUENCE OF:												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 3/20 1986 to 3/20 1986, that (I) (we) last saw the deceased alive on 3/20 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we said) I did not view the body after death.												
22b. SIGNATURE John P. Yew		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 3/20/86						
22e. PHYSICIAN'S NAME, TYPE OR PRINT John P. Yew		22f. ADDRESS Havre de Grace, Md										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/22/86		23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cemetery		23d. LOCATION City or Town Woodlawn		COUNTY		STATE Maryland		
24. FUNERAL DIRECTOR Loyd M. & Russell C. Witzke, Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, MD. 21228		25a. DATE REC'D. BY REGISTRAR MAR 21 1986		25b. REGISTRAR'S SIGNATURE Loyd M. Witzke								

14110-00



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10. FUNERAL DIRECTOR: After this certificate has been signed, it should be retained by the funeral director until 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 2 is marked or Item 18 is checked, any injury or other fracture, event, the medical examiner must be notified at once.

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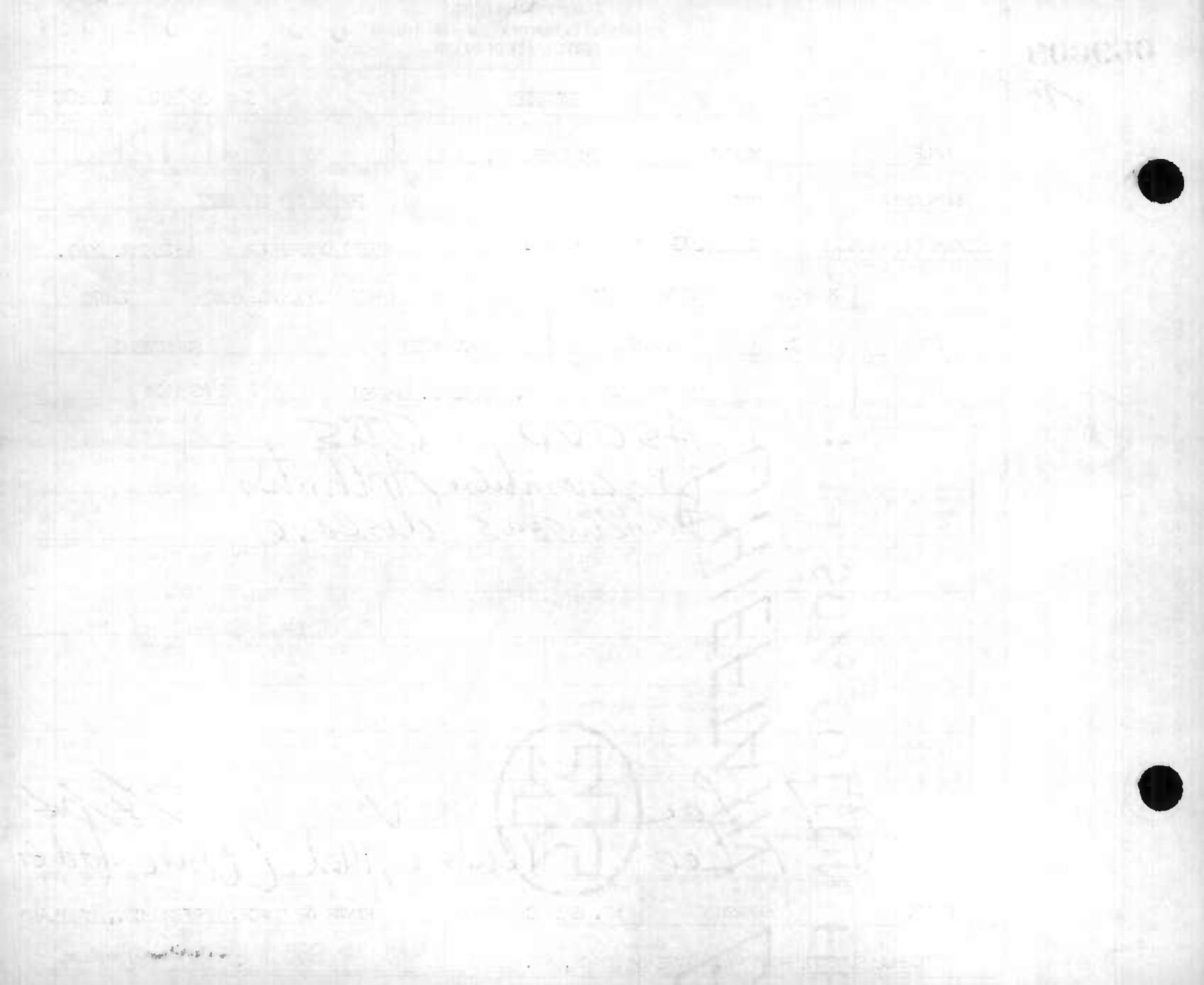
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 8 0 0 4

REG. NO.

1. FOR STATE REGISTRAR				2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
I. DECEASED NAME (TYPE OR PRINT) JOHN F LARNER						3	3	1986	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH OCTOBER		DAY 27,	YEAR 1896	6 AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS 89 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY			
10. CITY OR TOWN OF DEATH HAVRE DE GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITIZENS NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (RET) CARPENTER			12b. KIND OF BUSINESS OR INDUSTRY FEDERAL GOVT.		
13a. STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN HAVRE de GRACE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3401 OLD LEVEL ROAD 21078	
14. FATHER'S NAME FIRST JOHN		MIDDLE C.		LAST LARNER		15. MOTHER'S MAIDEN NAME FIRST MARGARET		LAST ARMSTRONG	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. SOCIAL SECURITY NO. 220 22 0947		17. INFORMANT MR. GERALD J. LARNER		ADDRESS SAME AS #13e	
18. CAUSE OF DEATH (Enter only one cause per line for Part 1b and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO, OR AS A CONSEQUENCE OF (b) Regenerative Arthritis DUE TO, OR AS A CONSEQUENCE OF (c) Parkinson's disease									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>J. Lee</i>		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (PRINT) <i>J. Lee</i>		22d. ADDRESS <i>Union Med. Clinic. Hdr</i>		22e. ADDRESS		22f. ADDRESS		22g. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6MARCH86		23c. NAME OF CEMETERY OR CREMATORIAL MT. ERIN CEMETERY		23d. LOCATION CITY OR TOWN HAVRE DE GRACE, HARFORD CO., MARYLAND		23e. COUNTY STATE	
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078		25a. DATE REC'D. BY REGISTRAR MAR 6 1986		25b. REGISTRAR'S SIGNATURE <i>Jordan Pendell</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be sent to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8608005			
1 - FOR STATE REGISTRAR			2d. DATE OF DEATH MONTH DAY YEAR 3 15 86							2b. HOUR 8:35 P.M.			
1 DECEASED NAME (TYPE OR PRINT) <u>Henrietta Helen Lauer</u>			MIDDLE			LAST		3d. DATE OF BIRTH MONTH DAY YEAR 3-12-1913			6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		
3. SEX Female			4. RACE White			5. CITIZEN OF WHAT COUNTRY? U.S.A.		6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			7b. CITY OF WHAT COUNTRY?			8.		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.					
10. CITY OR TOWN OF DEATH FALLSTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL			12a. USUAL OCCUPATION Home Maker		12b. KIND OF BUSINESS OR INDUSTRY Retired					
13a. STATE Md.			13b. COUNTY Harford			13c. CITY OR TOWN Edgewood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 631 Pier Drive - 21040		
14. FATHER'S NAME William Miller			15. MOTHER'S MAIDEN NAME Dora										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NUMBER 107-46-9692			17. INFORMANT Raymond A. Colton		18. ADDRESS 631 Pier Drive Edgewood, Md. - 21040			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH About 1 month		
18. CAUSE OF DEATH (Enter only one cause of death for Part I)													
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (18), stating the underlying cause lost													
DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FOLLOWING TESTS MADE IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 11			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3/16/86 to 3/16/86, that (I) (we) last saw the deceased alive on 3/16/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death													
22b. SIGNATURE <u>M. Miller</u>			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 3/16/86				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Lazarus, Daniel</u>			22f. ADDRESS PO Box 579 Aberdeen, MD 21001			22g. LOCATION CITY OR TOWN			22h. COUNTY STATE				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3-19-86			23c. NAME OF CEMETERY OR CREMATORIAL Jefferson Memorial Park			23d. SIGNATURE				
24. FUNERAL DIRECTOR John Miller Funeral home			ADDRESS 6415 Belgard Rd.			24e. SIGNATURE							
DHMH - 16 60M 7/84 (VRA 15, 4)													

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0 8 6 0 6

REG. NO.

1-
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE KNOWN OF ESTI- DEATH MATED	<input checked="" type="checkbox"/>	MONTH	DAY	YEAR	2b HOUR
William Henry Lindeman						3	13	19	86	M	
3. SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c DATE PRONOUNCED DEAD					
Male	White	May 24, 1937	48 yrs.			3	13	19	86	2d. HOUR 10:30 a.m.	
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Baltimore, Md.		USA				Harford County,					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
BelAir			603 Foxbow Drive			Convention Coordinator-Nat.Guard			21014		
13a. STATE Maryland			13b. COUNTY Harford		13c. CITY OR TOWN Bel Air	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 603 Fox Bow Drive, Bel Air, Md			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			ADDRESS Bel Air, Md. 21014					
Charles Melvin Lindeman			Clara Elizabeth Fowler								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Air Nat.Guard 1954-present			212-32-7254			Mary V. Lindeman, 603 Fox Bow Drive					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hanging DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? <input checked="" type="checkbox"/> 3 13 19 86			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject hanged self					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home			21f. LOCATION STREET 603 Foxbow Drive, BelAir, CITY OR TOWN COUNTY Harford, Md. STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE											
TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 3/14/86											
EXAMINER'S NAME (TYPE OR PRINT)			Gregory R. Kauffman, M.D.			ADDRESS			111 Penn St. Balto.MD.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial Mar. 17, 1986			23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gardens, BelAir			23d. LOCATION CITY OR TOWN COUNTY Harford Md. STATE		
24 FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Howard K. McComas III, Abingdon, Md. 21009											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be retained for use at the burial and funeral service. Then please remove carbon paper. Pages 1 and 2 should be left with the funeral director. If the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Name 2 is marked on Item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 0 8 6 0 /
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Eva</i>	MIDDLE <i>S.</i>	LAST <i>Lindsey</i>	2a. DATE OF DEATH MONTH <i>Mar.</i>	DAY <i>25</i>	YEAR <i>1986</i>	2b. HOUR 3:58 P.M.
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH <i>Feb.</i>		YEAR <i>1922</i>	6. AGE (IN YEARS LAST BIRTHDAY) YEARS <i>64</i>	7. UNDERTAKER MONTHS <i>0</i>	8. DIRECTOR MONTHS <i>0</i>	
7a. BIRTHPLACE COUNTRY <i>Indiana</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED NEVER MARRIED WIDOWED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i>	MD.			
10. CITY OR TOWN OF DEATH <i>Harrowde Grace Harford Memorial Hospital</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <i>Md.</i>		13b. COUNTY <i>Harford</i>	13c. CITY OR TOWN <i>Aberdeen</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>610 Plater Street/21001</i>		
14. FATHER'S NAME FIRST <i>Eston</i>		MIDDLE <i></i>	LAST <i>Hostettler</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Susan</i>		MIDDLE <i></i>	LAST <i>Stillhammer</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <i>N/A</i>		17. INFORMANT <i>James Lindsey, 610 Plater St., Aberdeen, MD.</i>		ADDRESS <i>21001</i>		
18. CAUSE OF DEATH (Enter only one cause per line for 10, 1b, and 1c.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		<i>Bilateral cerebral infarction</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		<i>Cerebral Thrombosis</i>						<i>1 month</i>
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Diabetes Mellitus</i>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. T9	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <i>2-23</i> , 19 <i>86</i> , to <i>3-25</i> , 19 <i>86</i> , that (I) <input type="checkbox"/> lost soul the deceased alive on <i>3-25</i> , 19 <i>86</i> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (did not) view the body after death.								
22b. SIGNATURE <i>B.J. Blunkett Jr.</i>		22c. DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	DATE SIGNED <i>3-26-86</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Mar. 29, 1986</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Harford Mem. Gdns.</i>			23d. LOCATION CITY OR TOWN <i>Aberdeen, Harford, Maryland</i>	COUNTY <i></i>	STATE <i></i>
24. FUNERAL DIRECTOR NAME <i>Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399</i>		25a. DATE REC'D. BY REGISTRAR <i>MAR 31 1986</i>						25b. REGISTRAR'S SIGNATURE <i>Joha Davidson-Henderson</i>
VRA 15, 4)								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, file in the funeral director's office. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked "None", show any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 8 0 0 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Hattie B</i>	MIDDLE <i>Louk</i>	LAST	2a. DATE OF DEATH MONTH DAY YEAR <i>March 27, 1986</i>	MONTH DAY YEAR	2b. HOUR <i>11:41 A.M.</i>	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 13, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County		MD.	
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME MAKER		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD	13b. COUNTY HARFORD	13c. CITY OR TOWN ABERDEEN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 418 STEPNEY ROAD 21001				
14. FATHER'S NAME FIRST ISAC		MIDDLE 	LAST BENDER	15. MOTHER'S MAIDEN NAME FIRST STELLA		MIDDLE 	LAST LOUK		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 226 34 6922		17. INFORMANT MRS. MYRTLE McCUALEY		ADDRESS SAME AS #13e			
18. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR 10, 11, AND 12) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Cerebral vascular thrombosis</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost		DUE TO, OR AS CONSEQUENCE OF (b) <i>Cerebro-vascular arteriosclerosis</i>							
		DUE TO, OR AS CONSEQUENCE OF (c) <i>Typho-meningo-cerebral disease</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 10 11 COPD <i>or pulmonary</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Irvin Wachman</i>		DEGREE							22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) IRVIN WACHMAN		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 31 MARCH 86		23c. NAME OF CEMETERY OR CREMATORIAL PENINSULA MEMORIAL PARK		23d. LOCATION CITY OR TOWN NEWPORT NEWS, -		STATE VIRGINIA	
24. FUNERAL DIRECTOR NAME Mitchell Funeral Home PA, HAVRE de GRACE, MD. 21078		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Jane Davidson-Ward					

34510-00



TO HOSPITAL OR ATTENDING PHYSICIAN. The

~~the client~~ be executed within 24 hours after death. Page 4 may be

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 18 8 6 0 9

REG. NO.

070079

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
Mattie M.					MaHANIS	March 1 1986			3:58 PM				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS (LAST BIRTHDAY))			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Female		Black		MONTH	DAY	YEAR	76						
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Harford			
Alabama		USA											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Harford		Harford Memorial Hosp		Retired			Gov.						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
Md.		Harford		Harford			YES			614 ERIE ST. 21078			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
BARRY				Thompson	Lula					Watson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO		220-01-4344		James Mahanis			614 Erie St			406. mol 1 day			
18. CAUSE OF DEATH: Enter only one cause per line for 1a, (b), and (c) PART I. DEATH WAS CAUSED BY													
IMMEDIATE CAUSE (a) cerebro - vascular thromboses													
DUE TO, OR AS A CONSEQUENCE OF (b) cerebro-vascular arterioles													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c.								
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 3-1, 1986, to 3-1, 1986, that (I) (we) lost saw the deceased alive on 3-1, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.													
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED					
Dr. Irvin H. Wachsman								3-2-86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Irvin H. Wachsman		57-South Union Ave., Harford, Md. 21078											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE		
Burial		3-8-86		BERKLEY			Darlington		Harford		MD.		
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Arnold Bearo		353 Fountain St Hdg. MD			MAR 07 1986			E. Bearo					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the Hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the funeral death permit. Then place remaining portion of certificate in the 72 hour after death envelope with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked on Item 18 showing injury, or other traumatic event, attach a separate sheet.

Item # 15 G 613 3/21/86 cw

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 5 10 8 0 1 0

REG. NO.

072193

1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Helen Elizabeth Meadows						3 9	86		2 A M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
FEMALE		WHITE		3 31 1916		69		YRS.		2 30	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Maryland		U. S. A.				Harford					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Harford		Harford Memorial Hospital		Housewife		None					
JULY RESIDENCE (NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13. COUNTY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
MD		CECIL		RISING SUN		491 TELEGRAPH RD. 21911					
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST				
JAMES			RIAE	ATHENUS Julia M.			RIAE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO		220-05-0350		HARVEY MEADOWS		491 TELEGRAPH RD. RISING SUN MD 21911					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory failure											
DUE TO, OR AS A CONSEQUENCE OF (b) Advanced Chronic obstructive pulmonary disease											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Acute renal failure											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/9 1985 to 3/4 1986, that (I) (we) lost saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did/did not view the body after death.											
22b. SIGNATURE SANG W. KIM		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED March 9, 1986					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SANG W. KIM		22e. ADDRESS 308 S Union Ave. Harford, Md									
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 3-12-86		23c. NAME OF CEMETERY OR CREMATORIAL West Nottingham		23d. LOCATION Colona		23e. COUNTY Cecil		23f. STATE MD	
24. FUNERAL DIRECTOR NAME R. T. Ford		ADDRESS Funeral Home Rising Sun Md.		25a. DATE REC'D. BY REGISTRAR MAR 19 1986		25b. REGISTRAR'S SIGNATURE					
VRA 15, 4)											

00-02019

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Retained by the hospital or attending physician.

11 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be retained by the funeral director until the burial permit is issued. Then please remove carbon paper pages 1 and 2 and be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8608611 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2d HOUR		
MARY JEANNINE MCKEE						MARCH 27 1986						11:50P.M.		
3. SEX:		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
FEMALE		WHITE		OCT 18 1931			54			YRS.	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
MD		USA					HARFORD COUNTY							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
EDGEWOOD		1618 PINE OAK RD								BUS DRIVER				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
MD.		HARFORD		EDGEGOOD						618 PINE OAK RD 21040				
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST						
JOHN			SCHRINGER	SARA										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS					
NO				214-28-6835			HOWARD MCKEE		same					
18. CAUSE OF DEATH (Enter only one cause per line for item (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DUE TO, OR AS A CONSEQUENCE OF (b) <u>OAT CELL CARCINOMA LUNG 6 mon</u>														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any										DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET						CITY OR TOWN	COUNTY	STATE		
22a. I certify that [I (this hospital)] attended the deceased from <u>3/25/86</u> to <u>3/28/86</u> , 19 <u>86</u> , the [I (we)] lost saw the deceased alive on <u>3/25/86</u> and that in my [our] opinion death occurred on the date and hour and from the causes stated above. I (we) did not see the body after death.										22c. DATE SIGNED <u>3/28/86</u>				
22b. SIGNATURE <u>John P. Edwards</u>		22c. DEGREE <u>MD</u>		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN						
22d. ADDRESS <u>2112 BEVAN R.D.</u>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY				
REMOVAL		MARCH 31, 1986		ST. MICHAEL'S			FROSTBURG			ALLEGANY MD				
24. FUNERAL DIRECTOR NAME		ADDRESS					25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
CONNELLY FUNERAL HOME 300 MACC AVE							APR 1 1986			<u>Julia Davidson-Randall</u>				

21080-00



00-01552

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 8 6 1 2

REG. NO.

1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Margaret E.</i>	MIDDLE <i>McKinley</i>	LAST	2a. DATE OF DEATH MONTH <i>April</i>	MONTH <i>7</i>	DAY <i>1986</i>	YEAR	2b. HOUR <i>1947 P.M.</i>		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH <i>April</i>	DAY <i>7</i>	YEAR <i>1892</i>	6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		7. IF UNDER 1 YEAR MONTHS 0	8. IF UNDER 24 HRS. HOURS 0	9. MIN. 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Hartford						
10. CITY OR TOWN OF DEATH Harcde Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hartford Mem Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home					
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Whiteford		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1524 Main Street/21160			
14. FATHER'S NAME FIRST James		MIDDLE 	LAST Wayne	15. MOTHER'S MAIDEN NAME FIRST Margaret		MIDDLE 	LAST Moore				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-24-1429		17. INFORMANT Jean E. Delp Ridge Road Whiteford, MD 21160		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line if you can). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Old Age											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. Acute viral infection - pulmonary embolism											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 13-10-1986 , that (I) (we) lost the deceased alive on 3-19-1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
23a. SIGNATURE <i>Dante Monakil</i>		23b. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>	IN DATE SIGNED 3/18/87		
23c. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE MONAKIL		23d. ADDRESS DANTE MONAKIL									
23e. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23f. DATE 3/21/86		23g. NAME OF CEMETERY OR CREMATORIAL Slate Ridge Cemetery		23h. LOCATION CITY OR TOWN Peachbottom Twp. York, PA		COUNTY	STATE		
24. FUNERAL DIRECTOR NAME John Harkins		24b. ADDRESS 600 Main Street Delta, PA		25a. DATE REC'D. BY REGISTRAR 1731 MAR 24 1986		25b. REGISTRAR'S SIGNATURE <i>John Harkins</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial permit. Then please return certificate to your registrar. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on item 18 above, any injury or other traumatic event, its medical cause must be listed on Part 1.

83-2115-00

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE COPIES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM P.M. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. COPIES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 0 8 6 1 3					
1- FOR STATE REGISTRAR																	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE KNOWN OF ESTI. DEATH MATED			MONTH	DAY	YEAR	2b HOUR					
BRANDY			Ann	MILLER		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3	28	1986	M					
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d HOUR					
Female	White	2 3 1986	7 weeks	MONTHS	DAYS	HOURS	MIN	3	28	1986	8:17 AM						
7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland			U.S.A.			Harford County											
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
Fallston			Fallston General Hospital									Infant					
13a STATE Maryland			13b COUNTY Harford			13c CITY OR TOWN Edgewood			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS 609 Burlington Court/ 21040					
14. FATHER'S NAME FIRST Robert			MIDDLE Lee			LAST Miller			15. MOTHER'S MAIDEN NAME FIRST Alice			MIDDLE Marie			LAST Cefalone		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
						Alice Marie Cefalone (same as 13e.)											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.																	
(b) DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20 AUTOPSY?					
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												TITLE (SPECIFY)					
												M.D. Assistant MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.												DATE SIGNED 3-29-86					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 3/31/1986			23c. NAME OF CEMETERY OR CREMATORY Holly Hill Mem Gds.			23d. LOCATION CITY OR TOWN Essex, Maryland 21220			COUNTY		STATE			
Burial																	
24 FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Walter Brooks Bradley Inc. Balto., Md. 21222						APR 01 1986											
DHMH - 17 (VR A15 ME (5))																	



071050

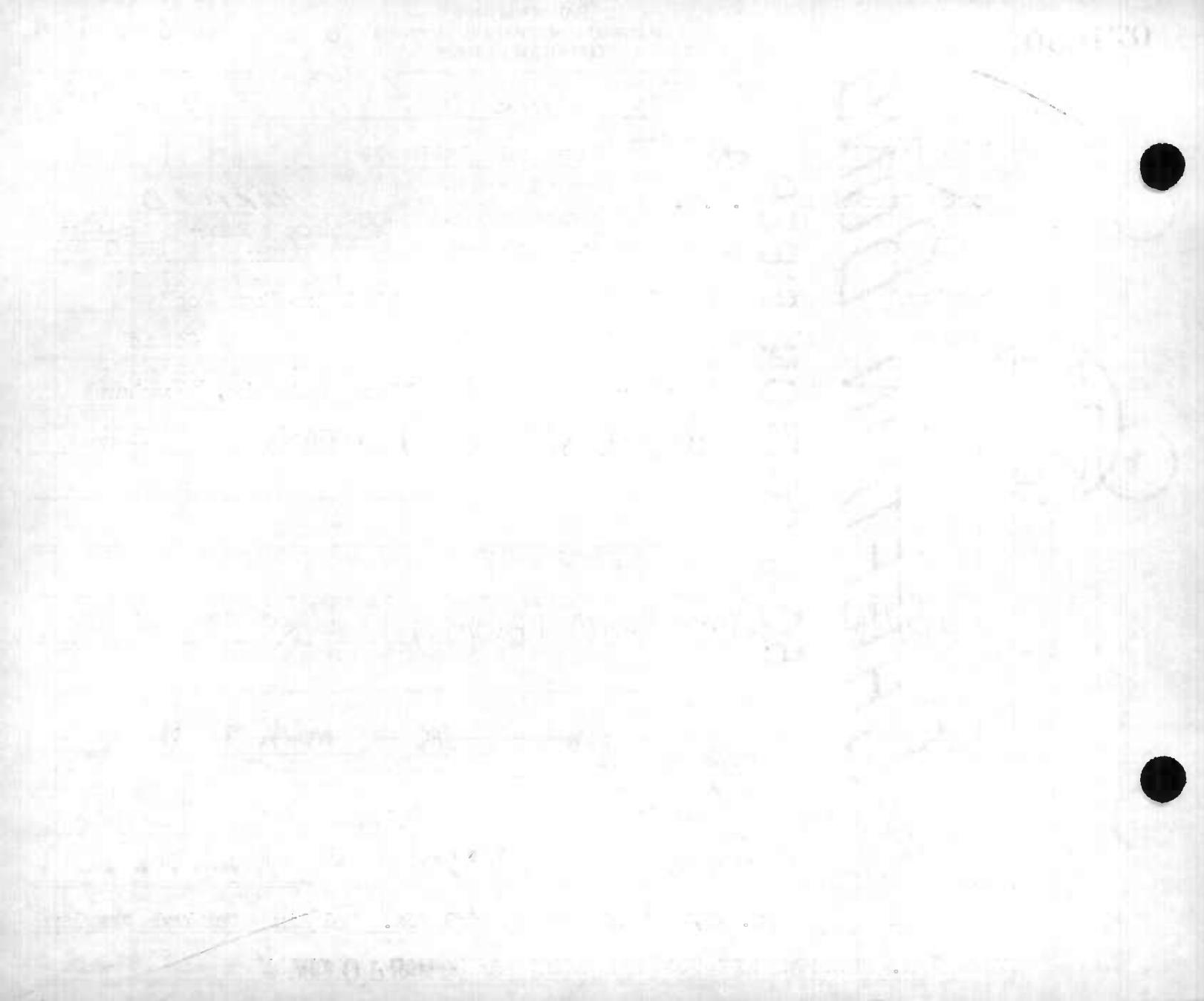
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon filer. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1 - STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR						3 6 0 8 6 1 4			
1b. DECEASED NAME (TYPE OR PRINT) VYRUS				FIRST VYKUS		MIDDLE SCHOOLCRAFT	LAST MILLER	2b. HOUR 9:10 p.m.					
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH May DAY 26 YEAR 1908			6. AGE (IN YEARS (LAST BIRTHDAY)) 77 YRS.		7b. IF UNDER 1 YEAR MONTHS 0 DAYS 0				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD			10. CITY OR TOWN OF DEATH Fallston			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON Gen Hosp.										12a. OCCUPATION Appliance & Furniture Store Owner		12b. KIND OF BUSINESS OR INDUSTRY Retail SALES	
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 101 Crafton Road 21014					
14. FATHER'S NAME FIRST George				MIDDLE Washington		LAST Miller	15. MOTHER'S MAIDEN NAME Jennie		16. ADDRESS 101 Crafton Road Bel Air, Maryland				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT M Ruth Miller		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver Cancer		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mo.					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION 2/21/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Liver Cancer (Biopsy)				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) March 7, 1986		21f. LOCATION STREET 2303 Bel Air Rd., Fallston, MD 21047		CITY OR TOWN Bel Air		COUNTY Harford		STATE Maryland			
22a. I certify that (I) (this hospital) attended the deceased from March 7, 1986 to March 7, 1986 , that (I) (we) lost sow the deceased alive on March 7, 1986 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 3/7/86			
22b. SIGNATURE Willard P. Amos		22c. DEGREE ATTENDING PHYSICIAN		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Willard P. Amos		22e. ADDRESS 2303 Bel Air Rd., Fallston, MD 21047							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Mar. 11, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gds.		23d. LOCATION CITY OR TOWN Bel Air		COUNTY Harford		STATE Maryland			
24. FUNERAL DIRECTOR NAME HOWARD K. MCCOMAS III		ADDRESS FUNERAL HOME ABINGDON, VA 24414		25a. DATE REC'D. BY REGISTRAR MAR 10 1986		25b. REGISTRAR'S SIGNATURE John Hudson Pendleton							
DHMH - 16 60M 7/84 (VRA 15, 4)													



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 08515
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED			MONTH	DAY	YEAR	2b. HOUR
Stephen			John	Misowitz	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		3/21/19	86	M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR
MALE	CAUCAS.	05 24 60	25			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3/21/19	86	P M	5:27
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
MARYLAND		USA						Harford County				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Fallston			Fallston General Hospital			CHEF			RESTAURANT			
13a. STATE MARYLAND			13b. COUNTY HARFORD		13c. CITY OR TOWN STREET		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3443 WILSON RD. 21154			
14. FATHER'S NAME FIRST			MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST			BOESHORE		
EDWARD					MISOWITZ		GRACE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
NO			215724159			LINDA MISOWITZ			3443 WILSON RD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY: 8/20 IMMEDIATE CAUSE (a) Multiple Injuries												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.												
(b)												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
						<input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> 10 AM MONTH DAY YEAR 4:10 P.M. 3/21/19 86			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of auto/auto/van collision						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway			21f. LOCATION STREET U.S. Rt. #1 North of Rt. #24, Harford Co. Md.			CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE _____												
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn St.												
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 03/26/86			23c. NAME OF CEMETERY OR CREMATORIAL GARDENS OF FAITH			23d. LOCATION CITY OR TOWN BALTO.			
24. FUNERAL DIRECTOR NAME _____ ADDRESS _____						24e. DATE REC'D. BY REGISTRAR MAR 24 1986			25b. REGISTRAR'S SIGNATURE J. Madison - Riddle			
BP _____												
DHMH - 17 (VR A15 ME (S))												

511-00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from items 1a and 2a and carbonponed. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, an other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8008616						
					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
LAFAYETTE — MONK						MARCH 7, 1986				10/10 AM	
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
MALE			WHITE	MONTH	DAY	YEAR	61	YRS	MONTHS	DAYS	IF UNDER 72 HRS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Virginia			U.S.A.						Harford County, MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
Darlington (21034)			4103 Conowingo Road			Electrician			U.S.Govt.		
13a STATE			13b COUNTY			13d. INSIDE CITY LIMITS?			13e STREET ADDRESS / ZIP CODE		
Maryland			Harford Co.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			4103 Conowingo Road		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST
John Thurmon Monk						Mary Ethel Stevens					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17. INFORMANT(WIFE) 457-4750 ADDRESS			4103 Conowingo Road		
YES - Army			W.W.2			Mrs. Margaret R. Monk			Darlington, Maryland 21034		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
18. CAUSE OF DEATH Enter only one cause per line for 1(a), (b), and (c). PART 1. DEATH WAS CAUSED BY											
IMMEDIATE CAUSE (a) Adenocarcinoma of lung with metastases 7 months											
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
9/25/85		Carcinoma of lung					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)						
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a I certify that (1) (this hospital) attended the deceased from Jan. 1950, 19, to Mar. 7/86, 19,											
saw the deceased alive on Jan. 17/86, 19,											
above, (1) (we) (did) (did not) view the body after death.											
22b SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED			
Robert Barthel Jr., M.D.								3/7/86			
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS						(Abode 638-6565)			
Robert A. Barthel, Jr., M.D.		2501 Rocks Road, Forest Hill, Maryland 21050									
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION CITY OR TOWN			
Burial		March 10, 1986			Highview Memorial Gardens			Fallston, Harford Co., Maryland 21047			
24. FUNERAL DIRECTOR		ADDRESS						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE
Joseph William Foster		So. Broadway & Williams Sts. Bel Air, Maryland 21014						MAR 11 1986			John Davidson -
Gurneville Treece											

12100+00

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician or by the hospital where the deceased was hospitalized.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be delivered to you or to the funeral director. Then please remove entire signature from Part 1 and attach it to the back of this certificate.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be consulted.

BP
DHMH - 16.60M 7/84
(VRA 15, 4)1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8608617

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
<i>Elburn R</i>					<i>Nutter</i>	<i>March 25, 1986</i>				<i>12⁵⁰ PM</i>			
1. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.			
MALE		CAUCASIAN		JANUARY 10, 1909		77		MONTHS DAYS		HOURS MIN.			
YRS.													
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
MARYLAND		USA				<i>Harford</i>							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
<i>Aurora de'Grasse</i>		<i>Harford Memorial Hosp</i>		RETIRED		MILITARY							
13a. STATE VIRGINIA		13b. COUNTY FAIRFAX		13c. CITY OR TOWN FT BELVOIR		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9100 RICHMOND HIGHWAY		99999			
FATHER'S NAME MERWIN		MIDDLE		LAST NUTTER		15 MOTHER'S MAIDEN NAME FIRST VICTORIA		MIDDLE		LAST POWELL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES		16b. SOCIAL SECURITY NO. WWII		17. INFORMANT DOROTHY H STAMBAUGH		ADDRESS ARLINGTON, VIRGINIA 2425 WILSON BLVD (22201)							
		577-38-6699											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) <i>Cardio pulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerotic cardiovascular disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <i>/</i> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs.</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
None													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>March 14, 1986</i> to <i>March 25, 1986</i> , that (I) (we) last saw the deceased alive on <i>March 24, 1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Andrew P. Trulley</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>3/26/86</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL SPECIES BURIAL		23b. DATE 4/1/86		23c. NAME OF CEMETERY OR CREMATORIAL THE NATIONAL CEMETERY		23d. LOCATION CITY OR TOWN ARLINGTON		COUNTY		STATE VIRGINIA			
24. FUNERAL DIRECTOR NAME DEMAINE FUNERAL HOMES, INC ALEXANDRIA, VIRGINIA		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Julie Davison-Pedde</i>							
				APR 8 1986									

10180-30



071038

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 8 6 1 8

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECLARED NAME (TYPE OF PRINT)		FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
		<i>Kazuo</i>			<i>March 4 1986</i>			<i>3:50 PM</i>	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		Oriental		Nov. 18, 1898		87 YRS		MONTHS DAYS	
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. IF UNDER 24 HRS	
Japan		U.S.A.				<i>Harford</i>			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
<i>Havre de Grace</i>		<i>Harford Memorial Hospital</i>		<i>Dry Cleaner</i>					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
Maryland		Harford		H de Grace				2200 Sherwood Lane/21078	
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES GIVE WAR OR DATES)		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
NO		N/A		143-22-1942		<i>Chiyoko Makino, 2200 Sherwood Lane, Havre de</i>		<i>Grace, MD, 21078</i>	
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART I. DEATH WAS CAUSED BY									
<i>Pneumonia</i>									
IMMEDIATE CAUSE									
SECONDARY AS A CONSEQUENCE OF									
3. ① old CVA ② old MI									
4. old MI									
5. old CVA									
6. old MI									
7. old CVA									
8. old MI									
9. old CVA									
10. old MI									
11. old CVA									
12. old MI									
13. old CVA									
14. old MI									
15. old CVA									
16. old MI									
17. old CVA									
18. old MI									
19. other significant conditions contributing to death but not related to the terminal disease or condition given in Part 1a									
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>3-13</i> , 19 <i>86</i> , to <i>3/4/86</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>3/4/86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DEGREE		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED			
<i>John J. Yuan</i>		<i>MD</i>		<i>John J. Yuan</i>		<i>3/4/86</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY STATE	
Removal/Cremation		Mar. 6, 1986		Chelten Hills Cem.		Philadelphia,		Penn. STATE	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399				MAR 10 1986		<i>John J. Yuan</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon copy pages 1 through 2 that will be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORT ANT: If Item 21 is marked as being "showing injury" or other traumatic event, the medical examiner must be notified at once.

90-1170

Trade

Trade

Trade

Trade

Trade

Trade

Trade

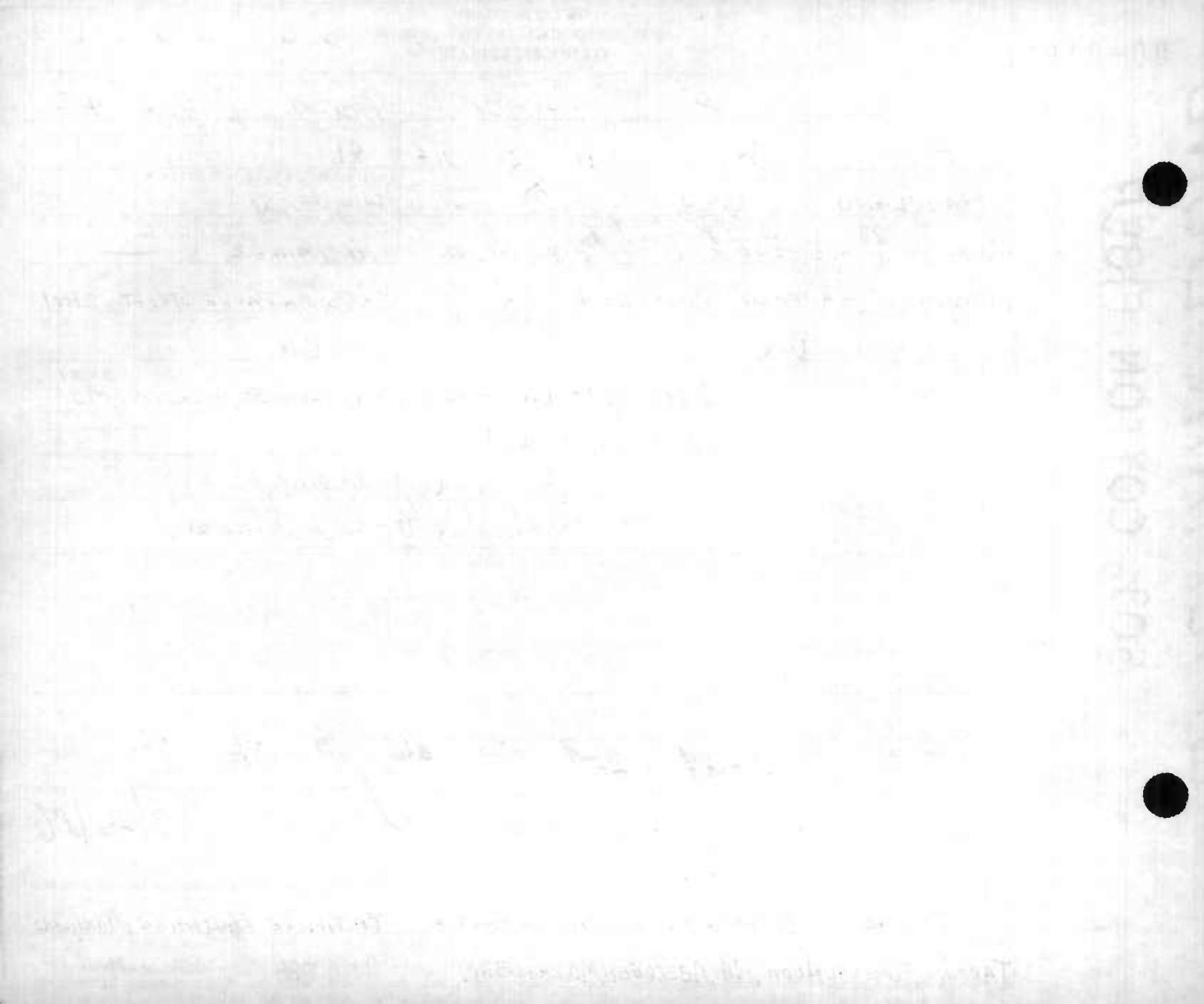
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 6 0 8 6 1 9															
												REG. NO.															
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR															
Rose F. Parker						March 24 th 1986						4:19 M															
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS															
F		W		MONTH	DAY	YEAR	81			MONTHS	DAYS	HOURS	MIN.														
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.																	
MARYLAND		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Harford																				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY												
Harford		Harford Mem. Hosp.										HOMEMAKER			—												
13a. STATE MARYLAND												13b. COUNTY HARFORD				13c. CITY OR TOWN ABERDEEN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 309 SOUTH PARKE STREET 21001			
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST	ADDRESS 21001																	
UNK					Louis A. PAKER, 309 S. PARKE ST., ABERDEEN, MD.																						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																		
No			212-05-9073			Cardiac arrest																					
18. CAUSE OF DEATH (Enter only one cause per line for item 18, or up to 3 causes for item 19.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)																											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first																											
DUE TO, OR AS A CONSEQUENCE OF (b)												Pulmonary edema															
DUE TO, OR AS A CONSEQUENCE OF (c)												calcific aortic stenosis															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?															
									YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE															
22a. I certify that (I) (this hospital) attended the deceased from 3-24-86 to 3-24-86, that (I) (we) lost sow the deceased alive on 3-24-86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/25/86																		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS																								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 26 MARCH 86			23c. NAME OF CEMETERY OR CREMATORIAL GARDENS OF FAITH			23d. LOCATION CITY OR TOWN BALTIMORE			COUNTY BALTIMORE		STATE MARYLAND													
24. FUNERAL DIRECTOR NAME TARRING FUNERAL HOME, PA., ABERDEEN, MD. 21001-3399			ADDRESS			25a. DATE REC'D. BY REGISTRAR MAR 31 1986			25b. REGISTRAR'S SIGNATURE John Davidson-Pender																		



00-0174

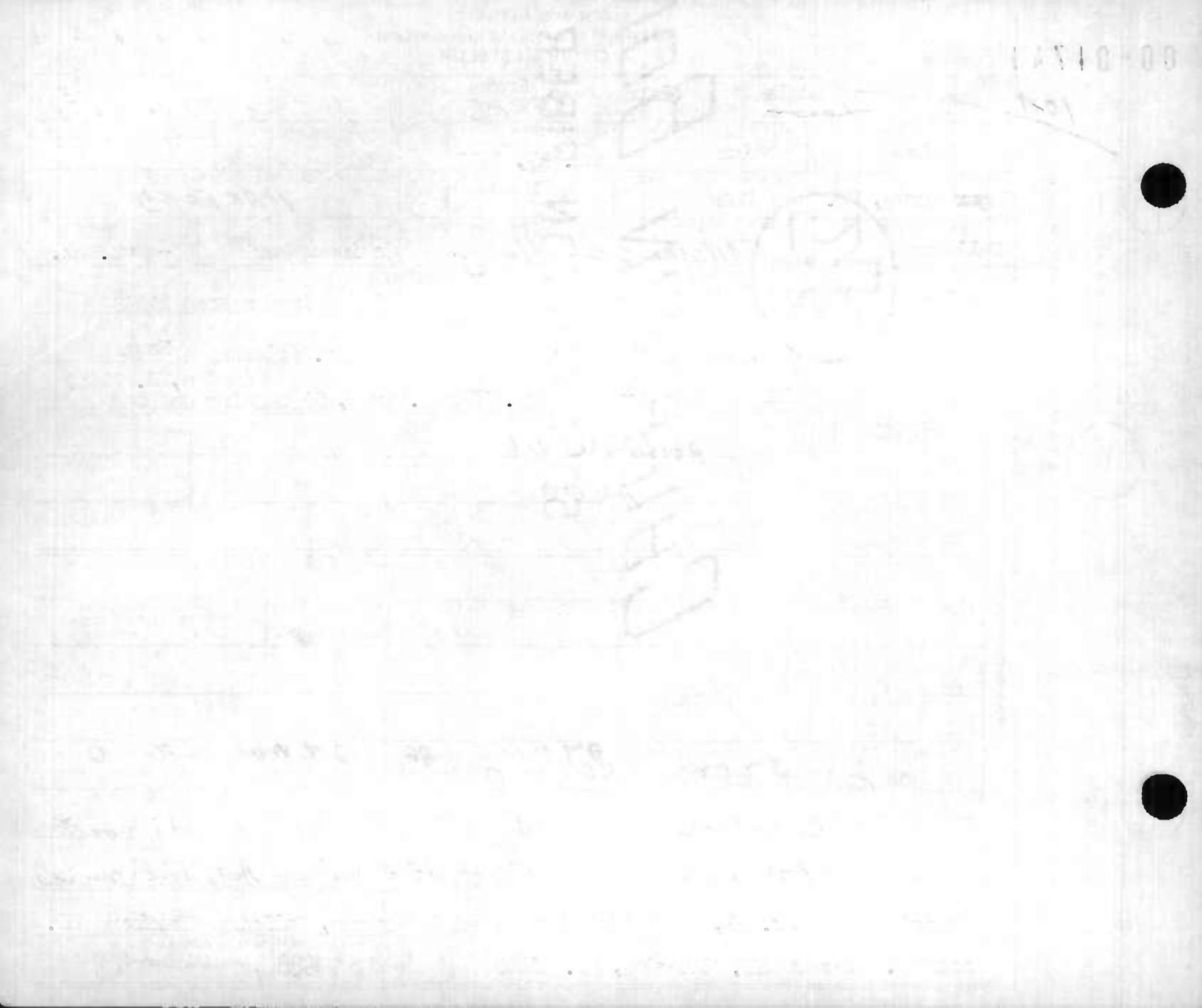
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 0 8 0 2 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST <u>Lusia</u>	MIDDLE <u>Claude</u>	LAST <u>Parks</u>	PARKS	20. DATE OF DEATH	MONTH	DAY	YEAR	26. HOUR
								3	27	86		4 13 P.M.
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		
Male		White		Month Day Year Oct. 17, 1917				68		MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH				
Sugar Grove, Va.		USA						Harford				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY		
Fallston		Fallston 6ew Hosg				Cabinetmaker				US-govt. Ret.		
MD.												
13a. STATE												
Maryland		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE				
		Harford		Abingdon		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3105 Abingdon Road 21009				
14. FATHER'S NAME		FIRST <u>George</u>	MIDDLE <u>Washington</u>	LAST <u>Parks</u>	15. MOTHER'S MAIDEN NAME		FIRST <u>Mary</u>	MIDDLE <u>Magdalene</u>	LAST <u>Haga</u>	ADDRESS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Abingdon, Md. 21009				
Yes		WWII		225-30-8959		Mrs. Ellen E. Parks, 3105 Abingdon Road						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>probable u1</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Age 84</u>												
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>27 Mar 86</u> , 19 <u>86</u> , to <u>27 Mar 86</u> , 19 <u>86</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>27 Mar 86</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) did not view the body after death.												
22b. SIGNATURE <u>J. E. Harrison</u>		22c. DEGREE <u>MD</u>				ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. E. Harrison</u>		22e. ADDRESS <u>FGH, 200 Main Ave, Fallston, MD</u>				22f. DATE SIGNED <u>27 Mar 86</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE		
Burial		Mar. 31, 1986		Highview Memorial Gardens, Fallston		Harford		Md.				
24. FUNERAL DIRECTOR NAME <u>Howard K. McComas III</u>		ADDRESS <u>Abingdon, Md. 21009</u>		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Jane Dawson-Bendell</u>						
				MAR 31 1986								

BP _____



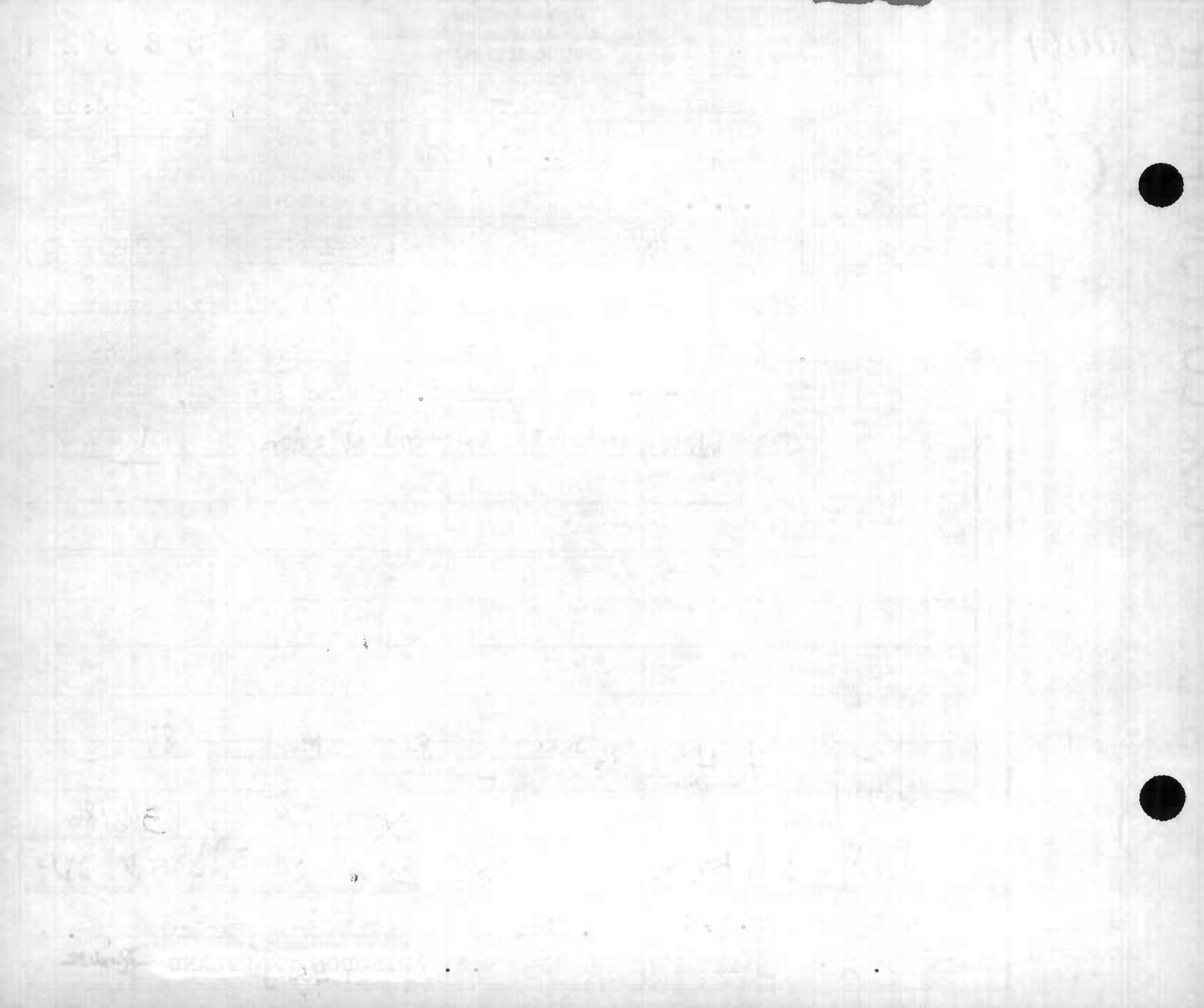
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removals.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86	08621		
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
THOMAS SHAW PADGETTE						March 6, 1986						4:00 AM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Male			White			Sept. 11, 1929			56			MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS	
North Carolina			U.S.A.						HARFORD			YEARS	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY				
Abingdon			3807 Washington Avenue			Executive Vice President			Contractor Maintenance				
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE			MD.	
Maryland			Harford			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			3807 Washington Avenue			21009	
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			ADDRESS			LAST	
Carl			R. Padgette			Della			3807 Washington Ave.			Patricia A. Padgette Abingdon, Maryland.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO			NONE 578-36-2639			Patricia A. Padgette			1 year				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a))										Widely metastatic carcinoma of colon			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), during the underlying cause (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
21a. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. AUTOPSY?			21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (SEE EITHER MEDICAL EXAMINER)			21f. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21g. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b PART 1 OR PART 2)							
21h. INJURY OCCURRED VEHICLE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21i. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21j. LOCATION STREET			21k. CITY OR TOWN	21l. COUNTY	21m. STATE		
22a. I certify that (i) this hospital attended the deceased from 4/4/86 to 1985, and that (ii) we last saw the deceased alive on 4/4/86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (i) (ii) did not view the body after death.										22b. DATE	22c. DEGREE		
22d. SIGNATURE Willard P. Amoss										22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22f. DATE SIGNED 3/6/86		
22f. PHYSICIAN'S NAME (TYPE OR PRINT) Willard P. Amoss			22g. ADDRESS 2303 Belair Rd Falls Church 20447										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE BURIAL Mar. 8, 1986			23c. NAME OF CEMETERY OR CREMATORIUM Mt. Zion			23d. LOCATION CITY OR TOWN Bel Air			23e. COUNTY Harford	23f. STATE Md.
24. FUNERAL DIRECTOR									25a. DATE REC'D BY REGISTRAR REGISTRATION SIGNATURE MAR 7 1986 Julie Davidson-Arendelle				
HOWARD K. MCCOMAS III FUNERAL HOME P.A.													



00-00041

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be retained by the funeral director in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8608622						
1 - STATE REGISTRAR										2a. DATE OF DEATH March 7, 1986	MONTH	DAY	YEAR	2b. HOUR 11p M		
1. DECEASED NAME (TYPE OR PRINT)			FIRST JOHN	MIDDLE	LAST PITTAM	5. DATE OF BIRTH MONTH JUNE DAY 19 YEAR 1908				6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
3. SEX Male			4. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Havre de Grace 619 Linden Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Minister				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland			13b. COUNTY Harford		13c. CITY OR TOWN Havre de Grace		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 619 Linden Lane/21078							
14. FATHER'S NAME FIRST William			MIDDLE	LAST Pittam	15. MOTHER'S MAIDEN NAME FIRST Mary				16. ADDRESS Klink							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. N/A		17. INFORMANT Martha Pittam; Same as Above				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory Failure																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) malignant melanoma																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. 14131 MONTH 3 DAY 25 YEAR 1986 P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) this hospital attended the deceased from 14131 1986, to 317 1986, that (we) lost saw the deceased alive on 14124 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.										22b. SIGNATURE DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> DATE SIGNED 3/10/86						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 203 So. Washington St. HDG, MD 21078													
Louis Silverstein, MD																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Mar. 11, 1986			23c. NAME OF CEMETERY OR CREMATORIAL Harford Memorial Gdns. Aberdeen, Harford, Maryland			23d. LOCATION CITY OR TOWN COUNTY				STATE			
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399			ADDRESS			25a. DATE REC'D. BY REGISTRAR MAR 12 1986			25b. REGISTRAR'S SIGNATURE							

1000-00

(1)

00-0155

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 6 0 8 6 2 3

REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 4 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, LONSDALE, MARYLAND. FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1-
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST WALTER	MIDDLE Rance	LAST PLACE	2a. DATE KNOWN OF ESTI- MATED <input type="checkbox"/>	MONTH 3	DAY 18	YEAR 86	2b. HOUR 9 AM
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH 12	DAY 23	YEAR 1986	AGE IN YEARS LAST BIRTHDAY 57	IF UNDER 1 YR. MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN. 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.		7b. CITIZEN OF WHAT COUNTRY? USA				MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUFFICIENT, GIVE STREET ADDRESS) FALLSTON GENERAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fork Lift oper.		12b. KIND OF BUSINESS OR INDUSTRY Steel			
13a. STATE MD		13b. CITY OR TOWN Harford		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1102 Falling Ranch Rd			
14. FATHER'S NAME FIRST Witfield		MIDDLE 	LAST Place	15. MOTHER'S MAIDEN NAME FIRST Carrie		MIDDLE 	LAST Snyder		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 074-24-0164		17. INFORMANT ELIZABETH Place		ADDRESS same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CORONARY Heart Disease						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF ASCVD - Diab							
		(b)							
		(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion	
ACTUAL SIGNATURE <i>Luis E. Krentel, M.D.</i>		TITLE (SPECIFY) M.D.						MEDICAL EXAMINER	DATE SIGNED 3/18/86
EXAMINER'S NAME (TYPE OR PRINT) Luis E. Krentel, M.D.		ADDRESS 401 Alliance St. Harford, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/21/1986		23c. NAME OF CEMETERY OR CREMATORIAL Jarrettsville Cem.		23d. LOCATION CITY OR TOWN Jarrettsville, Harford, Md.		23e. COUNTY M.D.	
24. FUNERAL DIRECTOR NAME M. Gladden Kurtz		ADDRESS Jarrettsville, Md.		25a. DATE REC'D. BY REGISTRAR MAR 24 1986		25b. REGISTRAR'S SIGNATURE Julie Krentel, M.D.			

BP _____
DHMH - 17
(VR A15 ME (5))
15M 2/80

for the removal of the

reservoirs of water in the area.

The reservoirs were removed by

the use of explosives and the

water was then removed by

the use of pumps and the

area was then cleared of all

debris and the area was then

reconstructed and the area was

then used for the construction

of a new reservoir in the area.

The new reservoir was then

constructed and the area was

then used for the construction

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use in the burial family permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as Item 18 showing injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3608624							
												REG. NO.							
1. STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)			FIRST	Floyd	MIDDLE	Edgar	LAST	Porter	PORTER	2a. DATE OF DEATH	MONTH	3	DAY	11	YEAR	86	2b. HOUR	9:05
																		M	
3. SEX	4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS						
Male	White			MONTH DAY YEAR July 11, 1903			82 YRS			MONTHS DAYS			HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.						
New York	USA									Harford									
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY												
Havre de Grace	Citizens Nursing Home			Trackman			Railroad												
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13e. STREET ADDRESS / ZIP CODE							
13a. STATE Maryland	13b. COUNTY Harford	13c. CITY OR TOWN Edgewood			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1123 Chipper Drive 21040											
14. FATHER'S NAME												15. MOTHER'S MAIDEN NAME							
FIRST Henry	MIDDLE Eugene	LAST Porter	FIRST Julia			MIDDLE Diantha	LAST Bargy												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --			17. INFORMANT Iva I. Matteson, 1123 Chipper Drive, Edgewood, Md			ADDRESS 21040										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____																			
DUE TO, OR AS A CONSEQUENCE OF Cardio - PULM - Atherosclerosis																			
DUE TO, OR AS A CONSEQUENCE OF Cardiac arrhythmia																			
DUE TO, OR AS A CONSEQUENCE OF Hypercholesterolemia Cardio - pulm. Dis.																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic Obstructive Lung Dis.																			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?												
				YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE										
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE _____ DEGREE _____												22c. DATE SIGNED							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>													
A. H. CALON, M.D.			611 S. UNION St. Havre de Grace																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE								
Burial-Removal		Boylston Cemetery			Sandy Creek			Oswego			N.Y.								
24. FUNERAL DIRECTOR NAME	ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE												
Howard K. McComas III, Abingdon, Md.	21009			MAR 13 1986															

0

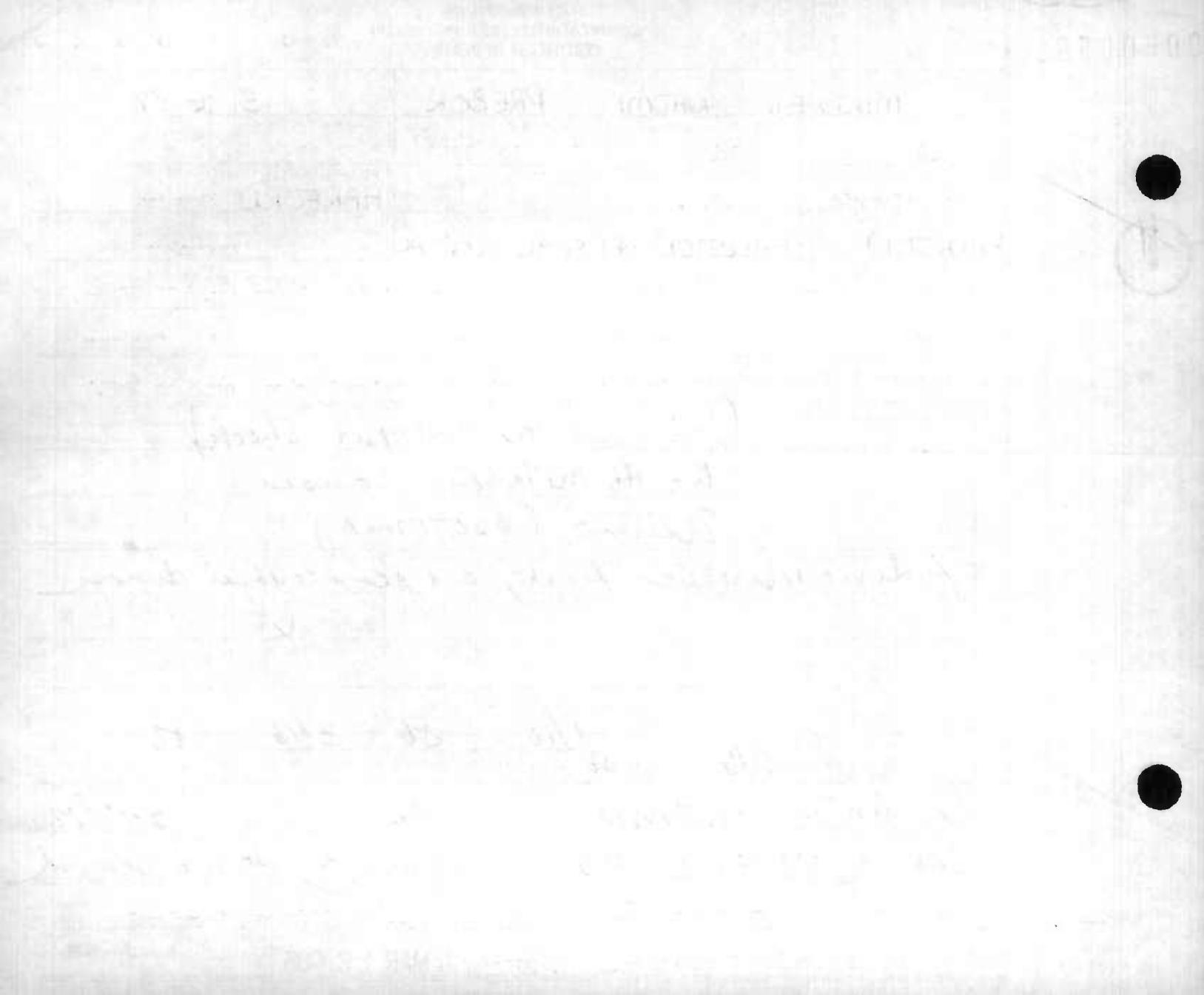
32100-00
RECEIVED
FBI - LOS ANGELES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 2 hours after it occurs. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene, 201 W. Preston St., Baltimore, Maryland 21201.

IMPORTANT: If item 21 is marked "No" to any injury or other traumatic event, the medical examiner will be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8608625
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d DATE OF DEATH	MONTH	DAY	YEAR	7b HOUR		
MILDRED NADMI PREBOR						3	16	86				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female		White		8 12 1902			83 YRS			MONTHS	DAYS	IF UNDER 24 HRS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH					
Pennsylvania		U.S.A.					HARFORD County			MD.		
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			12b USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
FAULSTON		FAULSTON GENERAL HOSPITAL		Maryland			Homemaker					
13a STATE		13b COUNTY		13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE			
Maryland		Harford		Churchville					2612 Palmyra Dr. / 21028			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
		Archie		Pratt				Edna		Eastman		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT			ADDRESS					
No		218/22/9774		Charles V. Prebor (husband-same as 1e3.)								
18 CAUSE OF DEATH (Enter only one cause per line for part I, II, and III) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular Collapse (Shock)</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Sic to Metabolic Cause</i>												
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Urinary (Azotemia)</i>												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>Arteriosclerotic final, cardiac & cerebral disease</i>												
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET 110 CITY OR TOWN 86 COUNTY 3166 STATE 62								
22a. I certify that (I) (this hospital) attended the deceased from 31/6 19 86 to 31/6 19 86, that (I) (we) last saw the deceased alive on 31/6 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 3/17/86
22d. SIGNATURE <i>Dante Monksir</i>		22e. DEGREE MD		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/18/1986		23c. NAME OF CEMETERY OR CREMATORIAL Green Mount Crematory			23d. LOCATION CITY OR TOWN Baltimore, Maryland COUNTY STATE					
24. FUNERAL DIRECTOR NAME Walter Brooks Bradley Inc. Balto., Md. 21222		ADDRESS		25a. DATE REC'D. BY REGISTRAR MAR 18 1986			25b. REGISTRAR'S SIGNATURE <i>John Anderson-Pendell</i>					



00-02093

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 8 6 2 6

REG. NO.

1 - STATE
REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST					2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR						
Mason A. Aubrey Pritt					3 30 86				6:00 AM						
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)								
Male		White		Month Day Year			If Under 1 Year Months Days Hours Min.								
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
Hot Springs, Va.		USA		Harford County MD.			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					
Fallston		Fallston General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
Md.		Harford		Bel Air			507 Pritt Lane 21014			LAST					
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
Samuel L. Pritt		Della		Bance			Yes			229-01-1304			Fannie M. Pritt, 527 Pritt Lane, Bel Air, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF <i>Asc VD</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>hours</i> <i>years</i>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED <i>White all white at work</i>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>Dean L. Van</i>		22c. DEGREE <i>MD</i>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>3/30/86</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial April 2, 1986			23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gardens, Bel Air			23d. LOCATION CITY OR TOWN Harford Md.		COUNTY		STATE			
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009		ADDRESS			25a. DATE REC'D. BY REGISTRAR APR 01 1986			25b. REGISTRAR'S SIGNATURE <i>Jean Harford Pendell</i>							

TO HOSPITAL OR AENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10. FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in, then please remove carbon paper. Then attach to burial permit. Then attach to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene group to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

32030-00

9000 COLLECTOR'S

BOOKS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial permit. Then please remove carbon copies pages 1 and 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked shows any injury, or other traumatic event, it must be reported to the State Dept. of Health and Mental Hygiene.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8608627			
1 - DECEASED NAME <small>(TYPE OR PRINT)</small>			FIRST Catherine	MIDDLE P.	LAST Quensen	2a. DATE OF DEATH MONTH DAY YEAR			DAY	MONTH	YEAR	2b. HOUR 05:22M			
3. SEX Female		4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug. 7 1902			6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.			7. IF UNDER 1 YEAR MONTHS DAYS			8. IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE COUNTRY Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD									
10. CITY OR TOWN OF DEATH ALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY -							
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Towson			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 305 E. Joppa Rd. 21204						
FATHER'S NAME FIRST G.		MIDDLE Alfred	LAST Peters	15. MOTHER'S MAIDEN NAME Minnie			16. SOCIAL SECURITY NO 216-01-8535D			17. INFORMANT Carol Morrow, 4101 Autumn Dr., 21084					
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No		19b. SOCIAL SECURITY NO -			20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease			minutes										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis			years										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Renal failure															
21a. MEDICAL CERTIFICATION DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)										
21g. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21h. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21i. LOCATION STREET			CITY OR TOWN			COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 2/28/86 to 3/1/86, that (I) (we) last saw the deceased alive on 3/1/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.															
22b. SIGNATURE Douglas L. Mallory		22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 3/1/86							
22f. PHYSICIAN'S NAME (TYPE OR PRINT) Douglas L. Mallory		22g. ADDRESS 9206 Lundigan Ct., Bethesda, Md. 20817													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/4/86			23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cem.			23d. LOCATION CITY OR TOWN Woodlawn			COUNTY Balto. STATE Md.				
24. FUNERAL DIRECTOR NAME J. E. Lowell Lemmon, 10 W. Padonia Rd.		25a. DATE REC'D. BY REGISTRAR MAR 3 1986			25b. REGISTRAR'S SIGNATURE Julia Davidson-Pandell										
DHMH - 16 60M 7/84 (VRA 15, 4)															

WATERFALL

WATERFALL

WATERFALL

00-01745

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 8 5 2 8

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME FIRST <i>DANIEL</i>			MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR		
			Ellsworth RAUDENBUSH			3-28-86			11 ²⁰ AM		
3. SEX MALE		4 RACE White	5. DATE OF BIRTH MONTH DECEMBER DAY 13, YEAR 1914			6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i>			MD.		
10. CITY OR TOWN OF DEATH <i>Havre de Grace</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Harford Memorial Hospital</i>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (RET) CLERGYMAN			12b. KIND OF BUSINESS OR INDUSTRY RELIGION			
13a STATE MD		13b COUNTY HARFORD	13c. CITY OR TOWN HAVRE de GRACE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 101 FAIRWAY COURT 21078				
14. FATHER'S NAME FIRST ALEXANDER		MIDDLE	LAST RAUDENBUSH	15. MOTHER'S MAIDEN NAME FIRST HENRIETTA			MIDDLE	LAST HARBISON			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 218 36 5068			17. INFORMANT ARNOLD RAUDENBUSH			ADDRESS 1008 GRACEVIEW DR. HdG, MO 21078			
18. CAUSE OF DEATH: Enter only one cause per line for 18(a) and 18(b). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CVT</i>											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF <i>acute myocardial infarction</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <i>John O'Yun</i>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>3/28/86</i>			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John O'Yun</i>		22f. ADDRESS <i>Havre de Grace, MD</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1APRIL86		23c. NAME OF CEMETERY OR CREMATORIAL ANGEL HILL CEMETERY			23d. LOCATION CITY OR TOWN HAVRE de GRACE, HARFORD CO., MD.				
24 FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078		25a. DATE REC'D. BY REGISTRAR MAR 31 1986			25b. REGISTRAR'S SIGNATURE <i>Juda Lewellen Raudenbush</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death, with the State Dept. of Health and Mental Hygiene given the burial, cremation, or removal.

IMPORTANT: If Item 18 is marked as "any injury, or other traumatic event," the medical examiner should be notified at once.

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XII 3rd Dec 2

1908-09 through

Dec 2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

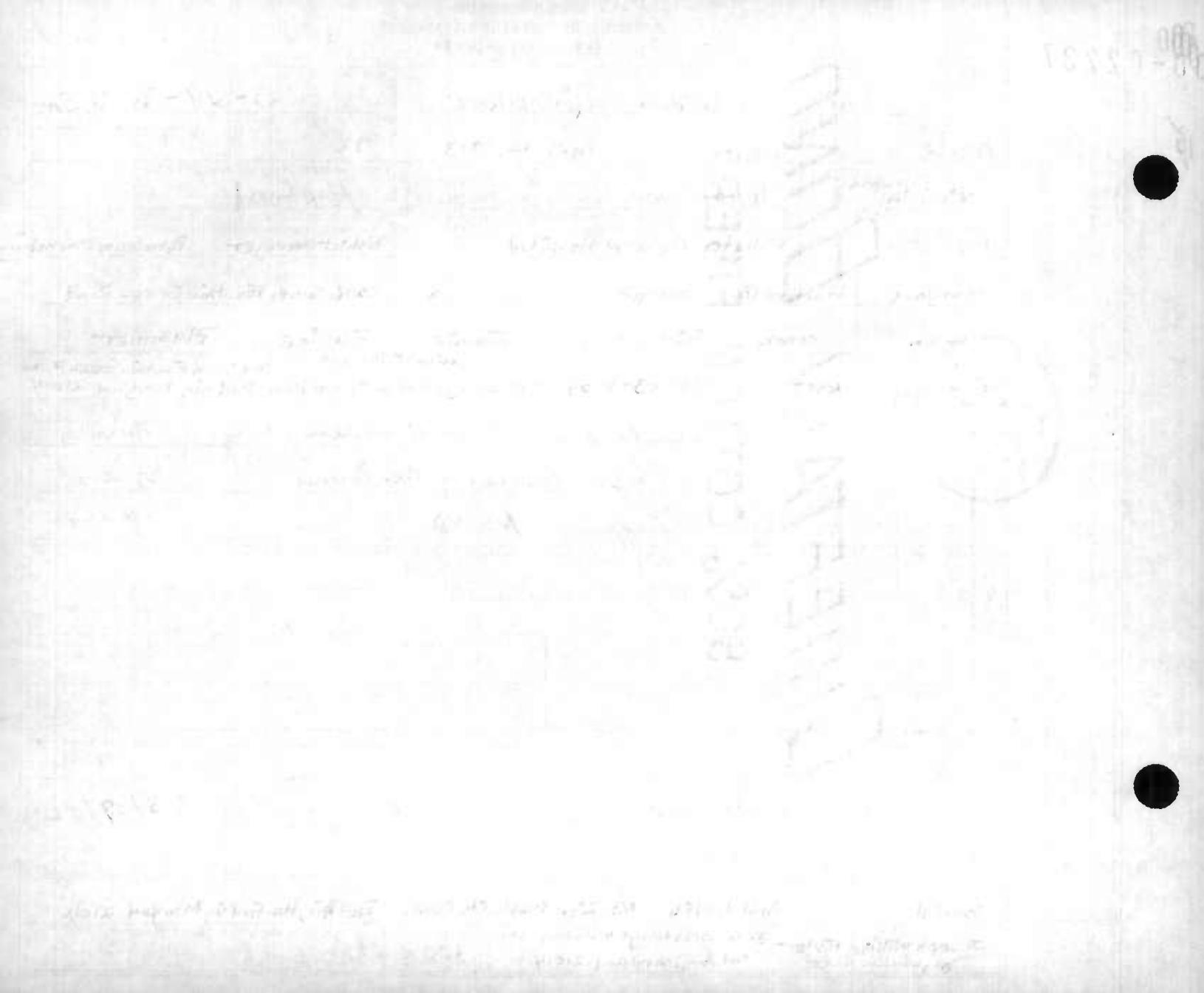
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it should be attached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT! If Item 21 is marked all that follows shows any injury, or other traumatic event, the medical examiner will be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 0 0 8 6 2 9			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Lacy Wilson Richardson						3-29-86						12:03 AM			
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR				
Male			White		Month Day Year April 12, 1913			72 YRS			IF UNDER 24 HRS MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Fairwood Virginia			United States						Harford						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Fallston			Fallston General Hospital									District Manager		Petroleum Marketing	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			31014		
Maryland			Harford Co.		Bel Air					306 South Fountain Green Road					
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO			17. INFORMANT (Nurse) 838-3008 ADDRESS			
Glen Mack Richardson						FANNIE Eunice Plummer			227-03-3034			306 South Fountain Green Road			
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			18b. SOCIAL SECURITY NO			18c. INFORMANT (Nurse) 838-3008 ADDRESS			18d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
YES - Army			WW 2			MRS. EVANGELINE J. RICHARDSON Bel Air, Maryland 21014									
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												aerobic MI vs Cerebral Hemorrhage			
Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause last												DUE TO, OR AS A CONSEQUENCE OF Triple Vessel Oc. Art Disease			
{												years			
(b)												Disease ASCVD			
{												years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 3/29/86			
22b. SIGNATURE <i>Darlene Jamison</i>												DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>VASSAR.</i>			22e. ADDRESS												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE April 1, 1986			23c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion Meth. Ch. Cem.			23d. LOCATION Bel Air, Harford Co., Maryland 21014						
Burial															
24. FUNERAL DIRECTOR <i>Joseph William Foster</i> <i>Funeral Director</i>			50W. Broadway Williams St. Bel Air, Maryland 21014			25a. DATE REC'D. BY REGISTRAR APR 1 - 1986			25b. REGISTRAR'S SIGNATURE <i>Susan Richardson</i>						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return both pages 1 and 2 to be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on the page 8 showing injury, or other traumatic event, the medical examiner will be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 6 0 8 5 3 0							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2d DATE OF DEATH MONTH DAY YEAR			2b HOUR 3 ⁰⁸				
ISABELLA AJELLO SALINES												3 13 86			3 ⁰⁸				
3. SEX		4 RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS						
Female		White		Month Feb. 19, 1913 Day Year			73 YRS.			MONTHS DAYS			HOURS MIN.						
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD. Harford County									
New York		U. S. A.																	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY				
Fallston		Fallston Gen. Hosp.										Nurse			Nursing Agency				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13e STREET ADDRESS / ZIP CODE							
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Joppa			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			616A Harborside Dr. 21085									
14. FATHER'S NAME Antonino		FIRST		LAST Ajello			15. MOTHER'S MAIDEN NAME Adelina												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			616 A Harborside Dr.									
no		050-14-3515		Mrs. Virginia Lemken,						Joppa, Md. 21085									
II. CAUSE OF DEATH (Enter only one cause per line for item 1b1 and 1c1) PART I. DEATH WAS CAUSED BY												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE (a) Cardiac arrest																			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b) End stage CM																			
DUE TO, OR AS A CONSEQUENCE OF Cause(s) of underlying disease (c) Bi-ventricular failure																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE								
22a. I certify that (I) (this hospital) sown the deceased alive or above, (I) (we) did (did not) view the body after death.		attended the deceased from 1976, 19 13, to 3/13, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated																	
22b. SIGNATURE		DEGREE										ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME & ADDRESS		22e. ADDRESS										V. S. NAIR		2112 Belair Road		Akhtekar		5/14/86	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE							
Burial		3-18-1986		Gate of Heaven Cemetery			Hawthorne					New York							
24. FUNERAL DIRECTOR NAME		ADDRESS		Kingsville, Md. 21087			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
Lassahn Funeral Home		11750 Belair					MAR 19 1986												
BP _____																			
DHMH - 16 60M 7/B4 (VRA 15, 4)																			

10000-00



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM P.M. J. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 00-00149	4 6 0 8 6 3			
1- STATE REGISTRAR			1 DECEASED NAME FIRST Gene			MIDDLE O'Neal			LAST Sanders Jr.			2a DATE KNOWN OF ESTI- DEATH MATED	□ MONTH DAY YEAR	2b HOUR		
												<input checked="" type="checkbox"/>	3 3 19 86	M		
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d HOUR
Male		Caucas.		Dec. 3, 55		30 yrs.		MONTHS		DAYS HOURS MIN		3 5 19 86		4:10P		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?						MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH				
Md.		U.S.A.						<input type="checkbox"/> WIDOWED		<input type="checkbox"/> DIVORCED		Harford County,				
10. CITY OR TOWN OF DEATH Forest Hill			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) off E. Jarrettsville Road			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY							
13a STATE Md.			13b COUNTY Harford			13c. CITY OR TOWN Forest Hill			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS 313 Whetstone Rd. 21050				
14. FATHER'S NAME FIRST Gene			MIDDLE O'Neal			LAST Sanders			15. MOTHER'S MAIDEN NAME FIRST Margaret			MIDDLE Ann			LAST Heimsath	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 212-70-4097			17. INFORMANT Janet L. Sanders same as above										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide intoxication												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?										
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 3 3 19 86			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) inhaled exhaust fumes from truck										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) farm			21f. LOCATION STREET CITY OR TOWN COUNTY STATE off E. Jarrettsville Rd, Forest Hill, Harford, MD.										
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Dennis F. Smyth, M.D.												Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion				
TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER												DATE SIGNED 3/6/86				
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.			ADDRESS 111 Penn St. Balto. MD.			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 3/8/86			23c. NAME OF CEMETERY OR CREMATORIAL Carroll Cremation			23d. LOCATION CITY OR TOWN Hampstead Carroll Md.	
24 FUNERAL DIRECTOR NAME Benjamin W. Kurtz			ADDRESS Jarrettsville, Md.			25a. DATE REC'D. BY REGISTRAR MAR 11 1986			25b. REGISTRAR'S SIGNATURE Julie Dawson-Pender							
(VR A15 ME (5))																
DHMH - 17																

00-01024

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 8 6 3 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Ella</i>	MIDDLE <i>Zena</i>	LAST <i>Scion</i>	2a. DATE OF DEATH MONTH DAY YEAR <i>March 15 1986</i>	MONTH DAY YEAR <i>IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.</i>	2b. HOUR 15 12 9 AM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10 21 08		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford		MD.	
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SURGICAL FACILITY, GIVE STREET ADDRESS) Hartford Mem Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Havre de Grace		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 408 Battery Dr. 21078	
14. FATHER'S NAME FIRST John Christy		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST Susie		MIDDLE Kenly	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-07-5523		17. INFORMANT Mary Scion		ADDRESS 408 Battery Dr. Havre de Grace Md.			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio - pulm. Arrest</i></p> <p>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastatic Br</i></p> <p>DUE TO, OR AS A CONSEQUENCE OF (c) <i>Ca Colon</i></p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>									
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET <i>2-27</i>		CITY OR TOWN <i>1986</i>		COUNTY STATE	
<p>22a. I certify that (1) (this hospital) attended the deceased from <i>3-15 1986</i> to <i>3-15 1986</i>, that (1) (we) last saw the deceased alive on <i>3-15 1986</i>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did/did not remove the body after death.</p>									
22b. SIGNATURE <i>CJ</i>		22c. DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED	
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-19-86		23c. NAME OF CEMETERY OR CREMATORIAL St. James		23d. LOCATION CITY OR TOWN Havre de Grace Harford Md.		COUNTY STATE	
24. FUNERAL DIRECTOR Arnold Beard		25a. DATE RECEIVED BY REGISTRAR MAR 20 1986				25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 3, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 3 AS A BURIAL TRANSIT REPORT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 08633		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR			2b. HOUR					
John			Gilbert	Shelley		3/12/1986	M							
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR			2d. HOUR 1:45 P.M.					
Male	White	July 7, 1969	16 yrs.			3/12/1986								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Balto. Md.		U. S. A.					Harford County							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Fallston		Fallston General Hospital			Student			Fallston H.S.						
13a. STATE Maryland		13b. COUNTY Harford	13c. CITY OR TOWN Fallston	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1115 Sturbridge Rd. 21047								
14. FATHER'S NAME FIRST Richard		MIDDLE H.	LAST Shelley	15. MOTHER'S MAIDEN NAME First Ruth		Middle M.	Last Quinn							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 218-08-5853		17. INFORMANT Mr. Richard H. Shelley, Fallston, Md. 21047		ADDRESS 1115 Sturbridge Rd. 21047								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Intoxication DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 3/12/1986			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject inhaled exhaust fumes from auto									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) garage			21f. LOCATION STREET CITY OR TOWN 1115 Sturbridge Rd., Fallston, Harford, Md.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE												TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT)												DATE SIGNED 3/13/86		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 3-15-1986		23c. NAME OF CEMETERY OR CREMATORIAL Highview Mem. Gardens			23d. LOCATION CITY OR TOWN Fallston		COUNTY Harford		STATE Md.			
24. FUNERAL DIRECTOR NAME		ADDRESS E.F. Lassahn F.H., 11750 Belair Rd. Kingsville, Md. 21007			25a. DATE REC'D. BY REGISTRAR MAR 18 1986			25b. REGISTRATION NUMBER						
BP _____														
DHMH - 17 (VR A15 ME (5))														

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00-02139

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 00000000000000000000000000000000

1- STATE
REGISTRAR1 DECEASED NAME
(TYPE OR PRINT)

FIRST John MIDDLE Wm LAST Simpson

2a. DATE KNOWN MONTH DAY YEAR
OF ESTI.
DEATH MATED 3-28 86 1986 2b HOUR
2c. DATE PRONOUNCED
DEAD 3 28 1986 0300 2d HOUR
2e. DATE OF DEATH
BALTIMORE CITY OR COUNTY OF DEATH
HARFORD

3 SEX

M

4 RACE

B

5 DATE OF BIRTH

MONTH 1
DAY 11
YEAR 226 AGE (IN YEARS
LAST BIRTHDAY)

64 YRS.

7 IF UNDER 1 YR.

MONTHS 0
DAYS 0

8 IF UNDER 24 HRS.

HOURS 0
MIN 09a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

USA

7b. CITIZEN OF WHAT COUNTRY?

USA

8 MARRIED NEVER MARRIED WIDOWED DIVORCED

9 BALTIMORE CITY OR COUNTY OF DEATH

HARFORD

10 CITY OR TOWN OF DEATH

Havre de Grace

11 USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

Md

13b. COUNTY

HARFORD

13c. CITY OR TOWN

Aberdeen

11a. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

HARFORD Memorial

13d. INSIDE CITY LIMITS?
YES NO

13e. STREET ADDRESS

458 CHESTNUT ST

14. FATHER'S NAME

John

FIRST

MIDDLE

Simpson

LAST

15. MOTHER'S MAIDEN NAME

Carrie

FIRST

MIDDLE

Carter

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

Yes

WW II

16b. SOCIAL SECURITY NO.

240-18-4545

17. INFORMANT

Hospital records

ADDRESS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CORONARY Heart Disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

ASCVD - Hypertension

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES NO

21a. EXTERNAL CAUSE WAS

UNDERLYING ORCONTRIBUTING CAUSE OF DEATHWHILE NOT WHILE AT WORK

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE NOT WHILE AT WORK 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an

Autopsy Inspection Inquiry

and in my opinion

death resulted from:

Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE Luis E. Renjel M.D. Deputy MEDICAL EXAMINER

DATE SIGNED 3-28-86

EXAMINER'S NAME
(TYPE OR PRINT)

Luis E. Renjel

ADDRESS 464 9TH ST. Havre de Grace MD 21078

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

4-2-86

23c. NAME OF CEMETERY OR CREMATORIUM

Berkley

23d. LOCATION
CITY OR TOWN

Darlington

Harford

Md.

24. FUNERAL DIRECTOR

Arnold Beard

ADDRESS

353 Fountain St. Havre de Grace

25a. DATE REC'D. BY REGISTRAR

APR 02 1986

25b. REGISTRAR'S SIGNATURE

Sue Davidson Pendell

9151-00

baseball

Yankees

Red Sox

Red Sox

Red Sox

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0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGE 1A AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 08635	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR	
William Henry Smallwood						<input checked="" type="checkbox"/> 3 3 19 86							
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR	
M	B	MONTH DAY YEAR 12 12 20	65 yrs.	MONTHS DAYS	HOURS MIN.	<input checked="" type="checkbox"/> 4 1 86						2:30P M	
7a. BIRTHPLACE - STATE OR FOREIGN COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Md.			U.S.A.						Harford County				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Joppatowne			Townwood Drive						Career Army			Govt.	
13a. STATE Md.			13c. CITY OR TOWN Balto.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 3616 Forest Hill Rd. 21207				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes 20 yrs.			16b. SOCIAL SECURITY NO. 218-09-6946	17. INFORMANT ADDRESS Aiko Smallwood 3616 Forest Hill
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 3 35 1986			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) unknown			21f. LOCATION STREET unknown			CITY OR TOWN	COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Dennis F. Smyth, M.D.</i> TITLE (SPECIFY) Assistant MEDICAL EXAMINER													
DATE SIGNED 4/2/86													
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 111 Penn St. Balto. MD.										
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)			23b. DATE 4/7/86	23c. NAME OF CEMETERY OR CREMATORIAL Crownsville			23d. LOCATION CITY OR TOWN Crownsville			COUNTY	STATE		
24. FUNERAL DIRECTOR NAME JAS. A. Morton & Sons - 1701 Laurens			ADDRESS						25a. DATE REC'D. BY REGISTRAR APR 07 1986			25b. REGISTRAR'S SIGNATURE <i>Julia Fairburn-Patterson</i>	

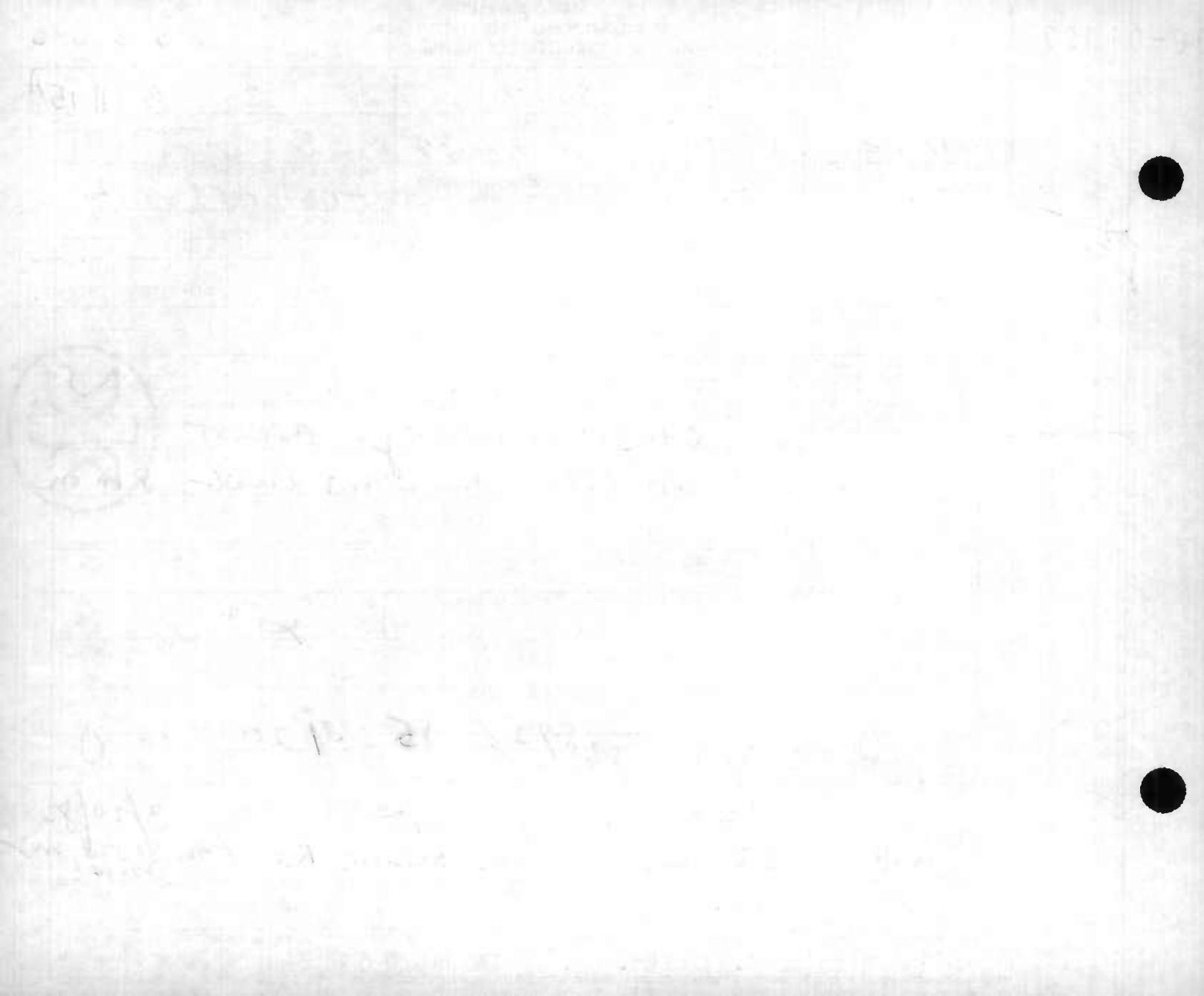
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within
retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be sent to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked show any injury, or other traumatic event, the medical examiner may require further examination.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Ann			E.	Smith		3 20 86			3	20	86	11:15 A.M.	
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female			White		11 03 27			58			MONTHS	YEARS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS	
PENNA.			U.S.A.						Harford County			MONTHS	DAYS
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY				
Fallston			Fallston General Hosp.			BRANCH MANAGER			BANKING				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												21085	
13a. STATE MD.		13b. COUNTY HARFORD		13c. CITY OR TOWN JOPPATOWNE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 622 Apt. A HARBORSIDE DR.				
14. FATHER'S NAME FIRST DAVID			MIDDLE PHILLIPS			15. MOTHER'S MAIDEN NAME FIRST MABEL			MIDDLE SMAWLEY				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT WM. J. SMITH (HUSBAND) SAME ADDRESS			ADDRESS				
NO			178-22-2126										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first (b) <u>CAT cau carcinomatous lung</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN					
22a. I certify that (I) (this hospital) attended the deceased from <u>3/19/86</u> to <u>31/20/86</u> , that (I) (we) last saw the deceased alive on <u>3/19/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If born dead mark here) _____ the body after death _____								COUNTY					
22b. SIGNATURE <u>John P. Edwards</u>					DEGREE <u>MD</u>			STATE					
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <u>John P. Edwards</u>		22d. ADDRESS <u>2112 Belair Rd. Fallston, Md. 21141</u>			ATTENDING MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			DATE SIGNED <u>3/20/86</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <u>3/21/86</u>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <u>GREENMOUNT</u>			23d. LOCATION CITY OR TOWN <u>BALTIMORE</u>			COUNTY <u>MD.</u>			
24. FUNERAL HOME NAME <u>CHIMUNEK FUNERAL HOME, INC.</u>		ADDRESS <u>9705 Belair Rd., Balto. Md. 21236</u>		25a. DATE REC'D. BY REGISTRAR <u>MAR 21 1986</u>			25b. REGISTRAR'S SIGNATURE <u>John P. Edwards</u>						



065015

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 0 8 5 3 /
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
<u>THOMAS m</u>			<u>SMITH, SR.</u>			<u>3</u>	<u>2</u>	<u>86</u>	<u>30</u>	
3 SEX		4 RACE	5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS	
MALE		WHITE	SEPT. 11, 1943			A2 yrs.			IF UNDER 24 HRS. HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. CITIZEN OF WHAT COUNTRY?			9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <u>HARFORD County MD.</u>		
MARYLAND		U.S.A.								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
<u>FALSTON</u>		<u>FALSTON GEN. HOSP.</u>			<u>SELF EMPLOYED</u>			<u>HOME IMPROVE.</u>		
13a. STATE <u>MARYLAND</u>		13b. COUNTY <u>HARFORD</u>	13c. CITY OR TOWN <u>JARRETTSVILLE</u>	13d. INSIDE CITY LIMITS? <u>S</u> <input type="checkbox"/> <u>NO</u> <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <u>2131 NELSON MILL RD. 21084</u>					
14. FATHER'S NAME FIRST <u>WILLIAM</u>		MIDDLE <u>H.</u>	LAST <u>SMITH</u>	15. MOTHER'S MAIDEN NAME FIRST <u>BALNCHÉ</u>			MIDDLE <u>M.</u>	LAST <u>BARTH</u>	ADDRESS <u>21084</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>-----</u>			17. INFORMANT <u>STEPHANIE I. SMITH JARRETTSVILLE, MD</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<u>Metastatic Carcinoma (Islet cell)</u>			<u>of Pancreas with massive</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any		(b) _____			<u>Liver Metastases</u>					
		(c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>January</u> , 19 <u>86</u> , to <u>March 2</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>March 2</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.										
22b. SIGNATURE <u>Willard P. Amoss</u>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>3/3/86</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Willard P. Amoss</u>		22e. ADDRESS <u>2303 Belair Rd. Fellston, MD 21047</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u>		23b. DATE <u>MARCH 4, 86</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>GREEN MOUNT CEMETERY BALTIMORE, MARYLAND</u>			23d. LOCATION CITY OR TOWN			COUNTY	STATE
24. FUNERAL DIRECTOR NAME <u>WILLIAM E. JOHNSON</u>		ADDRESS <u>8521 LOCH RAVEN BLVD.</u>	25d. DATE REC'D. BY REGISTRAR <u>MAR 4 1986</u>			25e. REGISTRAR'S SIGNATURE <u>Sue L. Jordan-Purcell</u>				
DHMH - 16 60M 7/84 (VRA 15, 4)										

211609



00-00476

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 8 6 3 8

REG. NO.

1-
FOR
STATE
REGISTRAR

1. DECEASED NAME <small>(TYPE OR PRINT)</small>			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
William T. Smith						3/13/86			3:45 am		
3: SEX:		4 RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR	
MALE		WHITE		JULY 1, 1904			81 YRS			MONTHS DAYS	
7a. BIRTHPLACE <small>STATE OR FOREIGN COUNTRY</small>		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. IF UNDER 24 HRS.	
MARYLAND		USA					Harford				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <small>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)</small>			12a. USUAL OCCUPATION <small>(TYPE OF WORK FOR MOST OF WORKING LIFE)</small>			12b. KIND OF BUSINESS OR INDUSTRY			
Havre De Grace		Citizens Nursing Home			NEVER WORKER						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
MD		HARFORD		HAVRE de GRACE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		316 BOURBON STREET			
14. FATHER'S NAME <small>FIRST MIDDLE LAST</small>		15. MOTHER'S MAIDEN NAME <small>FIRST MIDDLE LAST</small>									
JOSEPH L. SMITH		KATHERINE DONNELLY									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <small>(YES NO UNKNOWN) (IF YES, GIVE WAR OR DATES)</small>		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO		215 80 7507		PAUL M. WILLIAMS		1628 INGLESIDE AVE. PERRYVILLE, MD.					
18. CAUSE OF DEATH <small>(ENTER ONLY ONE CAUSE PER LINE FOR 18, 1b, AND 1c)</small>		PART I. DEATH WAS CAUSED BY <small>IMMEDIATE CAUSE (a)</small>			APPROXIMATE INTERVAL <small>BETWEEN ONSET AND DEATH</small>						
		<i>cardiorespiratory arrest</i>									
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause first		DUE TO, OR AS A CONSEQUENCE OF <i>Coronary insufficiency</i>									
		DUE TO, OR AS A CONSEQUENCE OF <i>Arteriosclerotic cardiovascular disease</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
21a. MEDICAL CERTIFICATION		21b. DATE OF OPERATION			21c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
							<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <small>(IF EITHER, NOTIFY MEDICAL EXAMINER)</small>		21e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21f. HOW INJURY OCCURRED <small>(ENTER NATURE OF INJURY IN ITEM 21, PART 1 OR PART 2)</small>						
21g. INJURY OCCURRED <small>WHITE <input type="checkbox"/> BLACK <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WORK <input type="checkbox"/></small>		21h. PLACE OF INJURY <small>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)</small>			21i. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (we) attended the deceased from 3/5/86 to 3/13/86, that (I) (we) last saw the deceased alive on 3/5/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, but did not view the body after death.											
22b. SIGNATURE		22c. DEGREE						22d. DATE SIGNED			
<i>T. T. Smith 81</i>								13 Ap' 86			
22e. PHYSICIAN'S NAME <small>(TYPE OR PRINT)</small>		22f. ADDRESS									
<i>H. Arakawa M.D.</i>		318 No. Union Ave. Havre de Grace									
23a. BURIAL, CREMATION, REMOVAL <small>IF APPLICABLE</small>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY		
CREMATION		14 MARCH 86		R. A. FERRIS + COMPANY			WEST CHESTER,		PA.		
24. FUNERAL DIRECTOR <small>NAME</small>		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078					MAR 17 1986			<i>Mitchell Pendle</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be

filled in by the funeral director; page 2 should be filed within 24 hours of death.

Important: If item 21 is marked as having

been filled in by the funeral director, the

certificate should be detached from the

original certificate and filed with the

State Dept. of Health and Mental Hygiene.

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been filled in by the funeral director, the

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2010 DEC 01

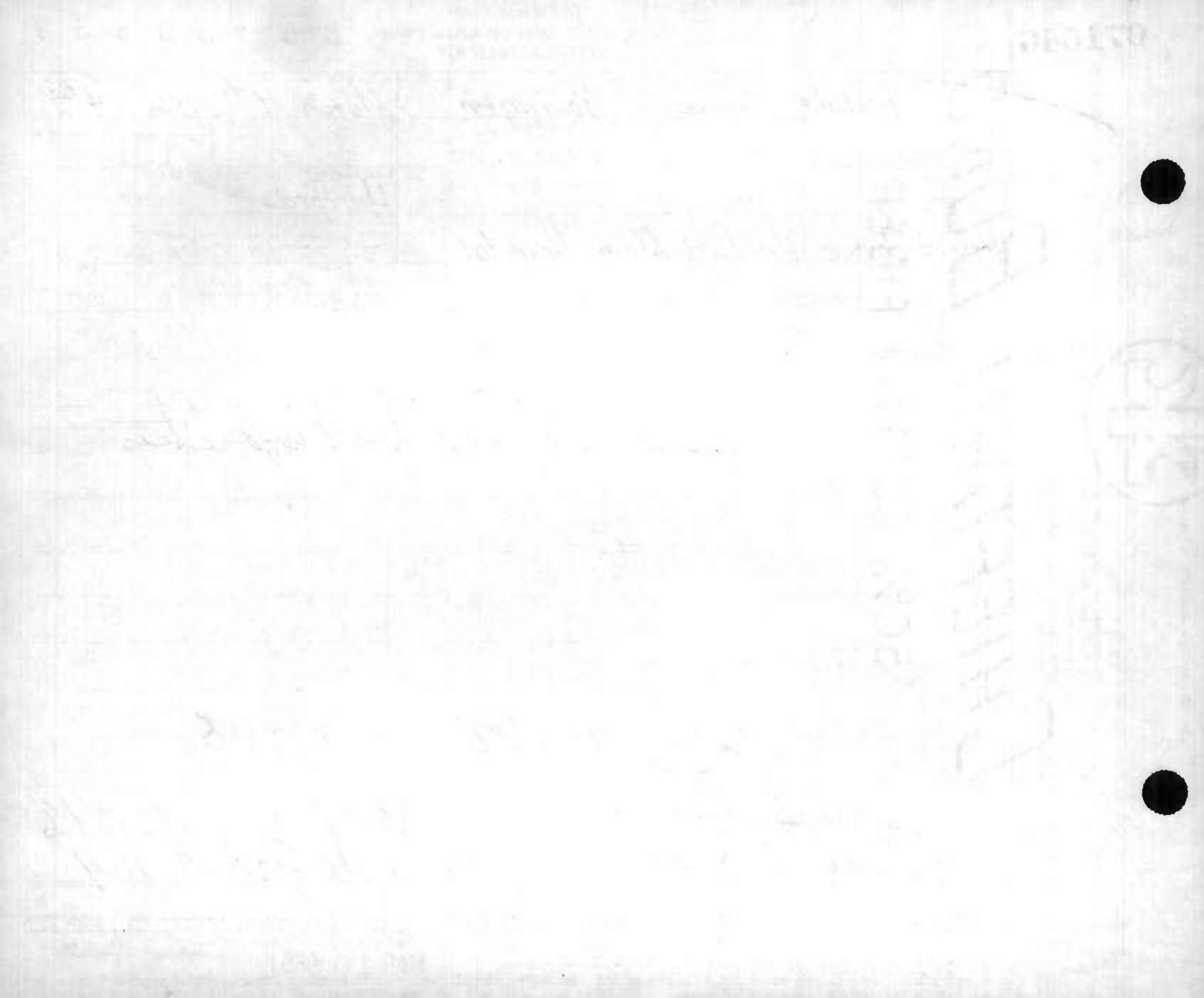
071046

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 8 6 3 9

REG. NO.

DECEASED NAME PRINT OR TYPE			FIRST <i>Thelma</i>	MIDDLE <i>BARNHART</i>	LAST <i>Springer</i>	REG. NO.
1. SEX FEMALE	4. RACE WHITE	S. DATE OF BIRTH MONTH DAY YEAR JANUARY 25, 1923	2a. DATE OF DEATH MONTH DAY YEAR March 7 th , 1986	2b. HOUR 4 PM		
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	
10. CITY OR TOWN OF DEATH <i>Havre de Grace</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Hartford Mem Hospital</i>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (RET) SECRETARY	12b. KIND OF BUSINESS OR INDUSTRY FED GOVT (APG)			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE MD	13b. COUNTY HARFORD	13c. CITY OR TOWN HAVRE de GRACE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 711 ALLIANCE STREET 21078		
14. FATHER'S NAME FIRST WILLIAM			15. MOTHER'S MAIDEN NAME FIRST CARRIE MIDDLE LAST MCVEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 213 20 3648	17. INFORMANT MR. RICHARD E. SPRINGER	ADDRESS SAME AS #13e			
II. CAUSE OF DEATH (Enter only one cause per line for 18, 19, and 20.) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (1a) <i>acute myocardial infarction</i>						
DUE TO, OR AS A CONSEQUENCE OF (1b) <i></i>						
DUE TO, OR AS A CONSEQUENCE OF (1c) <i></i>						
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i></i>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i></i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i></i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>3/7/86</i> to <i>3/7/86</i> , that (I) (we) last saw the deceased alive on <i>3/7/86</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Joyce D. Yuan</i>	DEGREE		ATTENDING PHYSICIAN <i>V</i>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Joyce D. Yuan</i>	22d. ADDRESS <i>Havre de Grace MD</i>		22e. DATE SIGNED <i>3/7/86</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 10MARCH86	23c. NAME OF CEMETERY OR CREMATORIAL ANGEL HILL CEMETERY	23d. LOCATION CITY OR TOWN <i>HAVRE de GRACE, HARFORD CO., MARYLAND</i>	23e. COUNTY <i></i>	23f. STATE <i></i>	
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078	ADDRESS		25a. DATE REC'D. BY REGISTRAR <i>MAR 10 1986</i>	25b. REGISTRAR'S SIGNATURE <i>John Pendleton</i>		

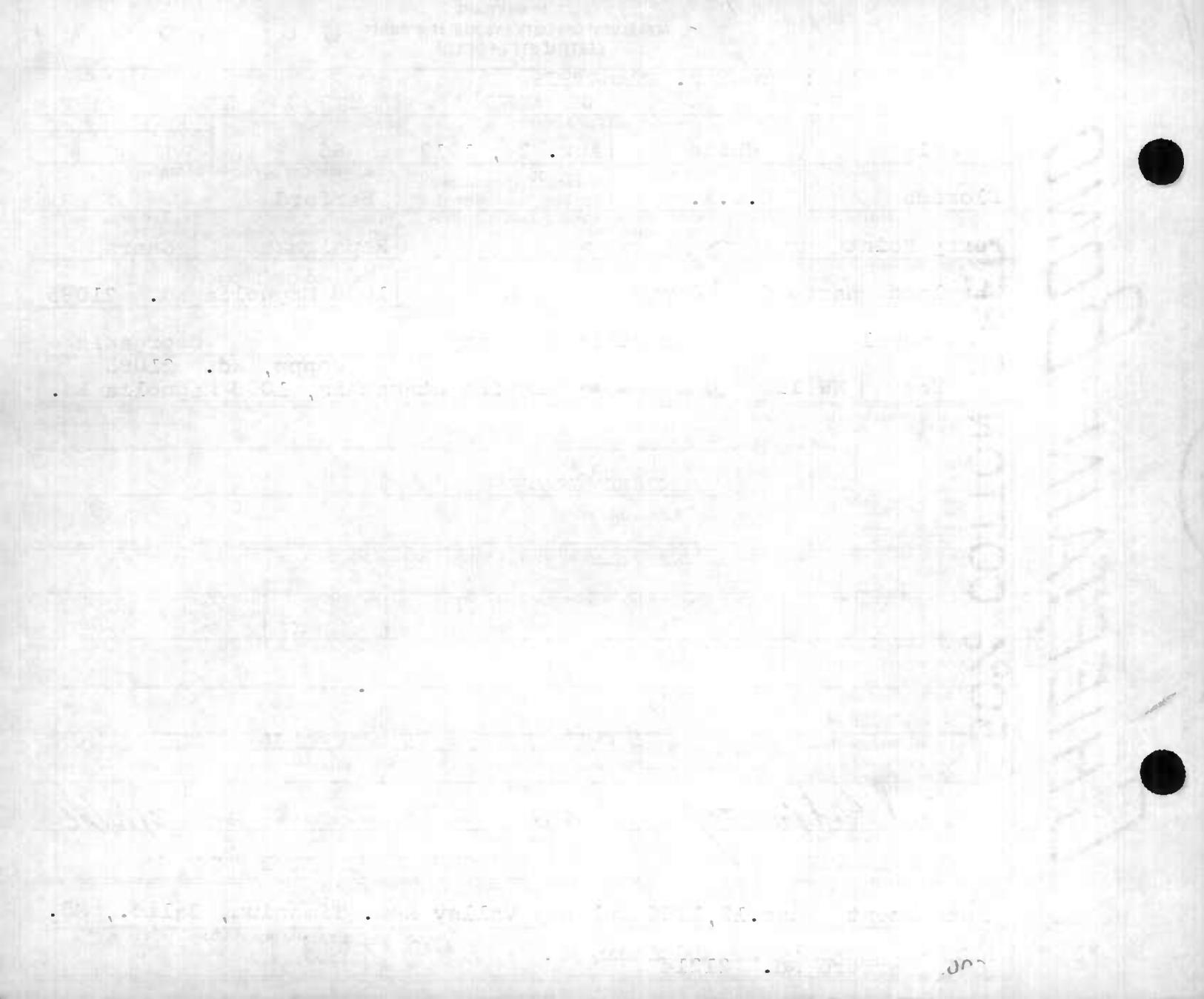


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
I. AKA: TONY ^{AKA} E. STAMATHIS ANTHONY E. STAMATHIS		MARCH 10 1986			5:30A M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Apr. 26, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Florida		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER PERRY POINT MD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Repairman		12b. KIND OF BUSINESS OR INDUSTRY Sears	
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Joppa		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Emanuel		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary		16. SOCIAL SECURITY NO. 230 05 5550		17. INFORMANT ADDRESS Joppa, Md. 21085	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		18b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		18c. SOCIAL SECURITY NO. 130 05 5550		18d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Louise Stamathis, 1008 Magnolia Rd.	
18e. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ALZHEIMERS DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.) MARCH 10 1986		21f. LOCATION STREET DECEMBER 20 1985		CITY OR TOWN VA MEDICAL CENTER PERRY POINT, MD	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 20 1985 to MARCH 10 1986 , that (I) (we) last saw the deceased alive on MARCH 10 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL SIDDOWAY M.D.		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22e. DATE SIGNED 3/10/86	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE Mar. 13, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Dulaney Valley Mem. Timonium, Balto., Md.		23d. LOCATION CITY OR TOWN COUNTY	
24. FUNERAL DIRECTOR Altenburg Funeral Home Baltimore, Md. 6009 Harford Rd. 21214		25a. DATE REC'D. BY REGISTRAR MAR 11 1986		25b. REGISTRAR'S SIGNATURE			



00-01835

1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 0 8 6 4 1
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
<i>Richard E. Stanley Sr.</i>						<i>March 26, 1986</i>	<i>10⁴⁵</i>		<i>AM</i>		
3- SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		July 21 1919		66		MONTHS	DAYS	HOURS	MIN.
7a BIRTHPLACE COUNTRY		7b CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
VA.		USA						<i>Harford Co.</i>			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY					
<i>Havre de Grace</i>		<i>Harford Memorial Hosp</i>		<i>Retired - Railroad</i>							
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE			
Md.		Balto.		Middle River				10212 Bird River Road 21220			
14 FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME					
Jackson				Stanley		Matty Lora		MIDDLE Beard LAST			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR ORDERS)		16c INFORMANT		ADDRESS					
yes		WW11		223-12-0735		Michael Stanley		10212 Bird River Rd. 21220			
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
<i>CARDIOPULMONARY ARREST</i>											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						2 WEEKS					
(b) <i>HEPATORENAL FAILURE</i>						3 WEEKS					
(c) <i>RESPIRATORY FAILURE</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> at WORK <input type="checkbox"/> at HOME <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a I certify that (1) (in hospital) attended the deceased from <i>3/16/86</i> to <i>3/26/86</i> , that (1) (we) last saw the deceased alive on <i>3/15/86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (not) (and will) view the body after death.											
22b SIGNATURE <i>Richard E. Stanley</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>3/26/86</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>John P. Edwards</i>		22e ADDRESS <i>212 Bier Ave Rd., Ansonia, MD 21001</i>									
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b DATE <i>3/27/86</i>		23c NAME OF CEMETERY OR CREMATORIAL <i>Security Process</i>		23d LOCATION CITY OR TOWN		COUNTY		STATE	
24 FUNERAL DIRECTOR NAME <i>Connelly Funeral Home</i>		ADDRESS <i>300 Mace Ave. 21221</i>		25a DATE REC'D. BY REGISTRAR <i>MAR 27 1986</i>		25b. REGISTRAR'S SIGNATURE <i>Anderson Pendleton</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be
used to detach for use on the hospital transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with 24 hours of death.
IMPORTANT: If Part 2 is marked as blank, any injury, or other traumatic event, the medical
attending physician must be notified of same.

22310-00



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in his presence, it should be forwarded for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 2 is marked or Item 18 shows any injury, or other traumatic event, the medical

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 6 0 8 5 4 2	
												REG. NO.	
1. FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			Violet L Stockdale						3 2 86			9 55 AM	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Female			White			August 21, 1912			73			MONTHS DAYS	
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS.	
Md.			U.S.A.						Harford			MONTHS HOURS MIN.	
III. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Harford Grace			Harford Memorial Hospital			Housewife			Home				
USUAL RESIDENCE IN NURSING HOME OR OTHER INSTITUTION. GIVE RESIDENCE BEFORE ADMISSION													
13a. STATE Md.			13b. COUNTY Cecil			14. CITY OR TOWN Rising Sun			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13d. STREET ADDRESS / ZIP CODE 1920 Theodore Rd 21911	
15. FATHER'S NAME FIRST MIDDLE LAST			16. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Oscar Blackson			Aiferetta Rice										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No			218-03-6459			Diane Racine			P.O. Box 357 North East, Md. 21901				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Respiratory failure													
DUE TO, OR AS CONSEQUENCE OF (b) COPD + CO2 narcosis													
DUE TO, OR AS CONSEQUENCE OF (c) ASLD													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20b. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1 OR PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) this hospital attended the deceased from saw the deceased alive on March 2 1986 and that in (my) court opinion death occurred on the date and hour and from the causes stated above. (I/we) did (did not) view the body after death.												22b. DATE SIGNED 3/2/86	
22c. SIGNATURE Jane Yun			22d. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 3/2/86							
22f. PHYSICIAN'S NAME, (TYPE OR PRINT) Jane Yun			22g. ADDRESS Harford Grace, Md.										
23a. BURIAL, CREMATION, REMOVAL METHOD			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL LOCATION			23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			3-5-86			North East Meth.			North East Cecil Md.				
24. FUNERAL DIRECTOR/FUNERAL HOME NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Talbot Johnson			MAR 5 1986			Jane Yunson-Randall							

10000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death.

IMPORTANT: If item 21 is marked or initialed, it should be destroyed for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene, Prison No Burial, cremation or other disposition.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8608643			
											REG. NO.				
1- FOR STATE REGISTRAR			2d. DECEASED NAME (TYPE OR PRINT)			LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
THEODORE X			TARNOVE			March 16 1986			750 AM						
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		2b. HOUR			
MALE		WHITE		MONTH 12 DAY 13 YEAR 24			58			MONTHS DAYS		750 AM			
7b. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.		IF UNDER 24 HRS.			
NEW YORK		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			HARFORD COUNTY MD.								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Fallston		Fallston General Hospital										ENGINEER		US GOVT.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
MARYLAND		HARFORD		EDGEWOOD						621 LACEWOOD DR. #21040					
14. FATHER'S NAME		FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME			FIRST MIDDLE LAST							
		JULIUS TARNOVE			BESSIE TARNOVE										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
YES		KOREAN -ARMY 109-20-5654			MRS. SYLVIA TARNOVE			621 LACEWOOD DR. EDGEWOOD, MD 21040							
18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u>															
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
(b) <u>ADEN CARCINOMA OF LUNG, METASTATIC</u>															
{ DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHRONIC DIC., 20 TO ABOVE</u>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____										
22a. I certify that (I) <u>David R. Padrino</u> attended the deceased from <u>3/15/86</u> , 19_____, to <u>3/15/86</u> , 19_____, that (I) <u>did</u> last saw the deceased alive on <u>3/15/86</u> , 19_____, and that in (my) <u>opinion</u> death occurred on the date and hour and from the causes stated above, (I) <u>did</u> <u>not</u> view the body after death.															
22b. SIGNATURE <u>David R. Padrino.</u>		22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>3/16/86</u>							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DAVID R. PADRINO</u>		22f. ADDRESS <u>1212 Churchville Rd., Bel Air, 21014</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAR. 19, 1986			23c. NAME OF CEMETERY OR CREMATORIAL HARFORD JEWISH CENTER			23d. LOCATION ROSEDALE BALTO. MD							
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.		ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215			25a. DATE REC'D. BY REGISTRAR MAR 24 1986			25b. REGISTRAR'S SIGNATURE <u>David R. Padrino</u>							

1932. 10. 20. 22. 23.

20. 21. 22. 23. 24. 25. 26.

27. 28. 29. 30. 31.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the physician notify the hospital or attending physician

within 24 hours after death. Page 4 may be executed within 24 hours after death.

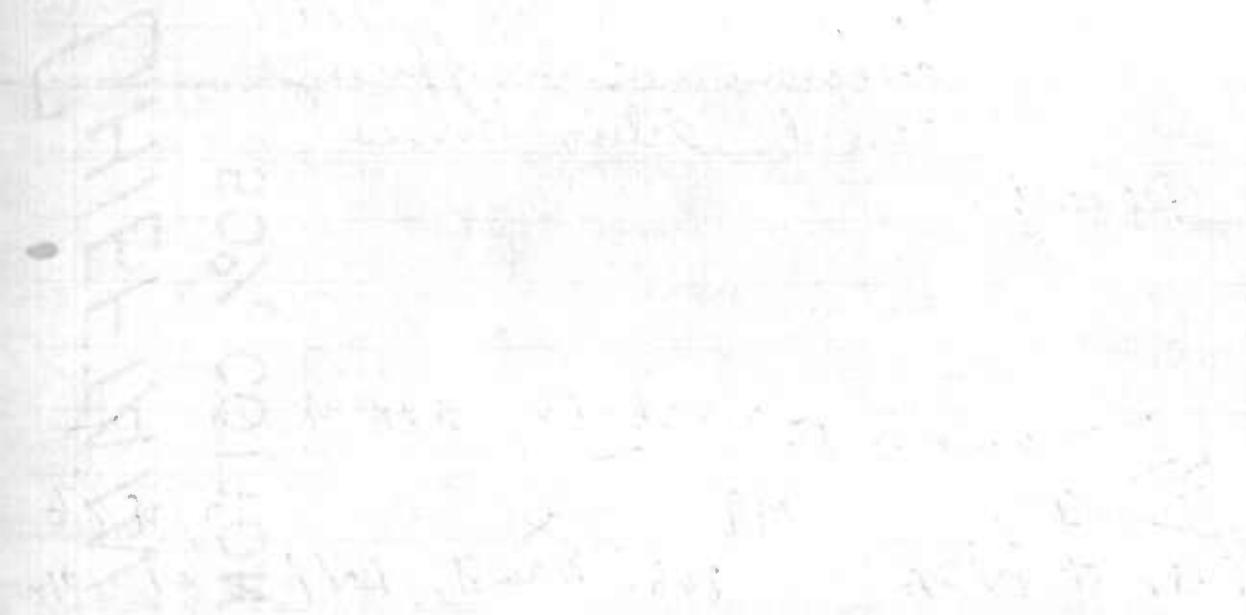
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be deposited for use as the burial permit. Then please remember to file this certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 000008644			
1 - FOR STATE REGISTRAR			20. DATE OF DEATH MONTH DAY YEAR							2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST		3-28-86			2 A.M.		
Virginia May						Taylor							
3. SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Female		White		Aug. 9 1918			67 YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maryland		U. S. A.					Harford Co.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IE NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Belair		Belair N. & Convalescent Ctr.							Homemaker			Home	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE					
Md.		Harford		Forest Hill				1906 Crouse Rd.			21050		
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST		
Reverdy H.				Jordan		Minnie			M.		Reynolds		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			21050	
---			215-18-7816			Mrs. Edna Hill, 1906 Crouse Rd. Forest Hill, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular insufficiency</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral arteriosclerosis</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Dementia</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>July 26 1982</u> to <u>Mar. 18 1986</u> , that (I) (we) last saw the deceased alive on <u>March 19 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (do) did not view the body after death.												22b. DATE SIGNED <u>3/28/86</u>	
22c. SIGNATURE <u>Ben Otey Jr.</u>		22d. DEGREE <u>M.D.</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS <u>8465 Main St., Bel Air, Md. 21014</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN		COUNTY		STATE		
Burial		3-29-1986		Belair Memorial Gar.			Belair		Harford Co.		Md.		
24. FUNERAL DIRECTOR NAME <u>Lorraine F. H. 750</u>		25. DATE REC'D. BY FURNITURE REG. DEPT. NAME <u>Belair P. & Kingsville Md. 21014</u>			DATE <u>31 1986</u>			SIGNATURE <u>Jane D. Johnson</u>					
												D.R.	

S 0000-0



00-02744

1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8608645
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Norman			Edward		Utter	March 30, 1986				8:30 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		Caucasian		Aug. 17, 1917		68		68 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Pennsylvania		U.S.A.				Harford		MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Whiteford		2953 Whiteford Road		Manager		Automobile					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13e. STREET ADDRESS / ZIP CODE								
Maryland	Harford	Whiteford	2953 Whiteford Road 21160								
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
Cyrus Utter			Elizabeth			(unknown)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
Yes WW II		215-18-9685		Marie T. Utter		same as above					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.											
{ DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE <u>John P. Edwards</u> DEGREE											
22c. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED			
John P. Edwards		2112 82nd Ave Rd						3/31/86			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE	
Burial		4/1/1986		Highview Mem. Gar.		Fallston, Harford, Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
M. Gladden Kurtz		Jarrettsville, Md.				APR 4 1986		John Gladden Kurtz			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours and completely filled in by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "No" any injury, or other traumatic event, the medical examiner must be notified.

00-01329

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 08546

REG. NO.

1 - FOR
STATE
REGISTRAR

I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			JOHN	JOSEPH	VAETH SR.	March 22, 1986				6:00 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Male		White		March 10, 1904		82		YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Howard County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Columbia		Howard County General Hospital		Truck Driver		Oil Company					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13e. STREET ADDRESS / ZIP CODE					
Maryland		Howard		Ellicott City		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		10058 Fox Den Road		21043	
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST		
Francis				Leopold	Anna			Mary	Bauer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
No		216-05-2314		George B. Vaeth		Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yes.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any (b) _____						DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Cardiovascular disease					
(c) _____						DUE TO, OR AS A CONSEQUENCE OF					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>12-20-1986</u> to <u>3-22-1986</u> , that (1) (was last seen alive on <u>Feb 27, 1986</u> and that in my <u>opinion</u> death occurred on the date and hour and from the causes stated above, (1) (was and could not) view the body after death.											
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				<u>Harry L. Kmipp M.D.</u>		<u>5411 Old Frederick Road, Baltimore, MD.</u>		22c. DATE SIGNED <u>3/24/86</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		CITY OR TOWN		STATE	
Burial		3/26/86		Holy Cross Cemetery		Baltimore		Baltimore		Maryland	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Leroy M. & Russell C. Witzke Funeral Homes 1630 Edmondson Avenue, Catonsville, MD. 21228		MAR 22 4 1986		<u>Ridson-Randall</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician or attending physician, it should be retained for use as the burial/transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified.

BP _____
DHMH - 16 60M 7/84
(VRA 15, 4)

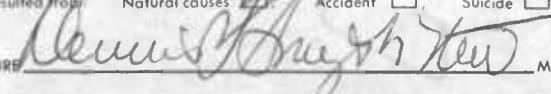
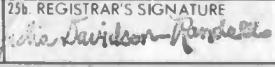
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.		11. DECEASED NAME (Type or print) Leonard A. Vogt		First	Middle	Last	2a. DATE OF DEATH Month 3 Day 5 Year 86		2b. HOUR 9:35PM	
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.		3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 3/6/1890		6. AGE (in years lost birthday) 95 YRS.		
7. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Co.				
10. CITY OR TOWN OF DEATH KINGSVILLE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2509 Loloa Drive		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Self-employed				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Kingsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 2509 Loloa Drive KINGSVILLE, MD. 21087		
14. FATHER'S NAME First Albrecht		Middle	Last	15. MOTHER'S MAIDEN NAME First Wilhelmine		Middle	Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO 216-16-5296		16c. INFORMANT Gulfred Vogt, son, same		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
		<p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) Pneumonia <small>DUE TO, OR AS A CONSEQUENCE OF</small> <small>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</small></p> <p>(b) Congestive heart failure <small>DUE TO, OR AS A CONSEQUENCE OF</small> <small>old age</small></p> <p>15 hrs</p> <p>7 days</p>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTO/PSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
				<small>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></small>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, nately medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (1) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (1) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.										
22b. SIGNATURE Phyllis K. Pullen MD		22c. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/>		22d. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22e. DATE SIGNED 3/5/86				
22e. ADDRESS 2807 Jerusalem Rd., Kingsville Md. 21087										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-8-1986		23c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery		23d. LOCATION (City or Town) PARKVILLE (County) Baltimore Co. (State) Md.				
24. FUNERAL DIRECTOR E.F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21086		ADDRESS		25a. REC'D BY REGISTRAR MAR 10 1986		25b. REGISTRAR'S SIGNATURE Julie Dawson-Pender				

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3 RETAIN A COPY FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 5 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 0 8 6 4 8		
1- STATE REGISTRAR		5/22/86 rja										
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST								2a. DATE KNOWN OF ESTI- DEATH MATED		2b. HOUR
Charles		Warfield								<input checked="" type="checkbox"/> 3	31 19 86	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN.	2c. DATE PRONOUNCED DEAD		2d. HOUR
M	B	5 22 51	34 yrs.							3	31 19 86	9:55P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED				9 BALTIMORE CITY OR COUNTY OF DEATH		
Md.		USA		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		Harford County,		MD.
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY		
Havre de Grace		Harford Memorial Hospital		Unemployed								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS				
Md.		Harford		Aberdeen				216 Bush Chapel Road 21001				
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Charles Franklin Warfield Sr.		Emma Cooper										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
Yes 1972-1975		218-46-2207		Emma Warfield		216 Bush Chapel Rd. Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Fatty Liver DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>												
(b) _____ DUE TO, OR AS A CONSEQUENCE OF												
(c) _____												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY?		
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion												
death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE  TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER												DATE SIGNED 4/2/86
EXAMINER'S NAME (TYPE OR PRINT)		Dennis F. Smyth, M.D.		ADDRESS		111 Penn St. Balto. MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE		
Burial		4/5/86		Mt. Calvary Cemetery		Aberdeen		Harford		Md.		
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Arnold Beard		353 Fountain St. Havre de Grece, Md.		APR 09 1986								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove corresponding papers 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, Item 18 shows only injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8608649			
1. DECEASED NAME CALVIN BURKETT WHISKEYMAN, JR.					2a. DATE OF DEATH MARCH 19, 1986			
1. SEX MALE					2b. HOUR 6:30 AM			
4. RACE WHITE					6. AGE (IN YEARS LAST BIRTHDAY) 51			
5. DATE OF BIRTH MONTH DAY YEAR July 4, 1934					IF UNDER 1 YEAR MONTHS DAYS YRS			
7b. CITIZEN OF WHAT COUNTRY? USA					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10. CITY OR TOWN OF DEATH Fallston					9. BALTIMORE CITY OR COUNTY OF DEATH Harford County			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Fallston General Hospital					12a. USUAL OCCUPATION Material Control			
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13c. STATE Maryland					12b. KIND OF BUSINESS OR INDUSTRY Electronics			
13b. COUNTY Harford					13d. STREET ADDRESS / ZIP CODE 2950 Kingsmark Court 21009			
13c. CITY OR TOWN Abingdon					13e. ADDRESS Abingdon, Md. 21009			
14. FATHER'S NAME FIRST MIDDLE LAST Calvin Burkett Whiskeyman, Sr.					15. MOTHER'S MAIDEN NAME Emma Bernadette Kacelowicz			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 191-24-1035			
17. INFORMANT Margaret J. Whiskeyman, 2950 Kingsmark Court					18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Unknown			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory arrest</i>					DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic congestive heart disease</i> - years			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERRYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (we) attended the deceased from <u>4</u> , 19 <u>85</u> , to <u>death</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>21/4</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>L.F. Kroger</i>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 3/20/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>L.F. Kroger</i>		22e. ADDRESS 120 Sister Pierre Dr.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 22, 1986		23c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		23d. LOCATION CITY TOWN Bel Air		
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009		ADDRESS		23e. COUNTY Harford		23f. STATE Md.		
23g. DATE REC'D. BY REGISTRAR MAR 24 1986					23h. REGISTRAR'S SIGNATURE <i>Sylvia Davidson Pendleton</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please send item 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial or removal.

BP _____

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8608650	
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
ELIZABETH D. WHITAKER						3 22 1986				6:10 P M	
3. SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		March 11, 1905		81 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Maryland		USA				HARFORD COUNTY					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
HAVRE DE GRACE		CITIZENS NURSING HOME						Division Manager		Md. Dept. of Employment Security	
13a RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE		13b COUNTY		13c CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e STREET ADDRESS / ZIP CODE			
Maryland		Cecil		Port Deposit		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		120 Beachwood Dr. 21904			
14 FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST	
Clarence		C.		Day		Beatrice				Herlich	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE PATIENT WEIGHT (GROSS AND NET)			
No		213-01-2749		Henry F. Coudon Jr.		103 Brotherton Ct 21078		1 week			
18. CAUSE OF DEATH (Enter only one cause per line for Part I, II, and III) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>A. S.C.V.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>recurrent</i> 2 years.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Inmesenteric arterial insufficiency</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH?			
						<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/1/86 to 3/23/86, that (I) (we) last saw the deceased alive on 3/1/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE <i>Edward C. Loo</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/23/86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Edward C. Loo, MD</i>		22e. ADDRESS <i>Havre de Grace, Md. 21078</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 25, 1986		23c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery		23d. LOCATION Baltimore City Maryland					
24. FUNERAL DIRECTOR See A. Patterson & Son Perryville, Maryland		25a. DATE REC'D BY REGISTRAR MAR 24 1986		25b. REGISTRAR'S SIGNATURE <i>John P. Donohue</i>							
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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 0 8 6 5 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death be reported and completely filled in by the attending physician. Page 4 may be retold by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached from the burial permit. Then please remove with the State Dept. of Health and Mental Hygiene prior to burial, cremation or interment.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
			John	S.	Wilson	3	20	86	11:45 A.M.				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR				
Male		White		MONTH 9	DAY 10	YEAR 26	59			MONTHS YRS.	IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH				
Bayonne, N. J.		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Harford County			Belair				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
725 High Plain Drive 21014		Ret. Navy Archc.			Gulf Oil								
13a. STATE Maryland						13b. COUNTY Harford		13c. CITY OR TOWN Belair		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 725 High Plain Dr. 21014	
14. FATHER'S NAME FIRST John			MIDDLE Scott	LAST Wilson	15. MOTHER'S MAIDEN NAME FIRST Annie			MIDDLE B.	LAST Lennox				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO WW 11			17. INFORMANT Agnes G. Wilson 725 High Plain Dr. 21014			ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Adenoca Lt. Lung w/ multiple Bone						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months.							
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)						mets.							
DUE TO, OR AS A CONSEQUENCE OF (c)						Cirrhosis of liver.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 85 to 3-20 19 86, that (I) (we) last saw the deceased alive on 3-15 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) did not view the body after death.													
22b. SIGNATURE <i>Burk</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/21/86							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Parekh		22e. ADDRESS 838-8855		22f. ADDRESS 1908 Harford Rd. Fallston, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-24-1986		23c. NAME OF CEMETERY OR CREMATORIAL Garrison Forest Vet.Cem.		23d. LOCATION City or Town Owings Mills, Balto.		23e. COUNTY		23f. STATE Md.			
24. FUNERAL DIRECTOR NAME E.F. Lassahn & F.H.		24b. ADDRESS P.O. Box 147 11750 Belair Rd. Kingsville, Md. 21087 MAR 24 1986		24c. DATE REC'D. BY REGISTRAR 24d. REGISTRAR'S SIGNATURE John Davidson									

00-01222



00-00328

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached from the burial permit. Then place them with the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked on Item 18 below any injury, or other significant event, the medical examiner will be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.				
1. FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	MAR. 9, 1986							1:45 P.M.	
MILLIE L. WILSON														
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.		
FEMALE			WHITE		MONTH DAY YEAR AUG. 23, 1899		86			MONTHS DAYS		HOURS MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.				
ST. MICHAELS, MD.			U.S.A.				HARFORD CO.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
JOPPA			410 TIMBER LA.							HOUSEWIFE			MD.	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		ZIP CODE		
MD.			HARFORD		JOPPA					410 TIMBER LA.		21085		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			ADDRESS					
CORNELIUS					THOMAS	MOLLIE			FAMILY RECORDS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO		17. INFORMANT			ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO			579-01-0456											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) BRAIN MENINGITIS														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) GENERALIZED METASTASIS.														
DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD.														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 3-25 1986, to 3-25 1986, that (I) did not view the body after death.														
22b. SIGNATURE			22c. DEGREE		22d. ATTENDING PHYSICIAN			MEDICAL DIRECTOR		STAFF PHYSICIAN		22e. DATE SIGNED		
RUBEN S. SEBASTIAN												3/10/86.		
23a. BURIAL, CREMATION, REMOVAL SPECIAL			23b. DATE 3-12-1986		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION CITY/TOWN			23e. DATE REC'D. BY REGISTRAR			
BURIAL			3-12-1986		MORELAND MEM. PARK			PARKVILLE			MAR 14 1986			
24. FUNERAL DIRECTOR EVANS CHAPEL OF MEMORIES, PARKVILLE			25e. REGISTRAR'S SIGNATURE											
			Randall											

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1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 0 8 6 5 3
REG. NO.

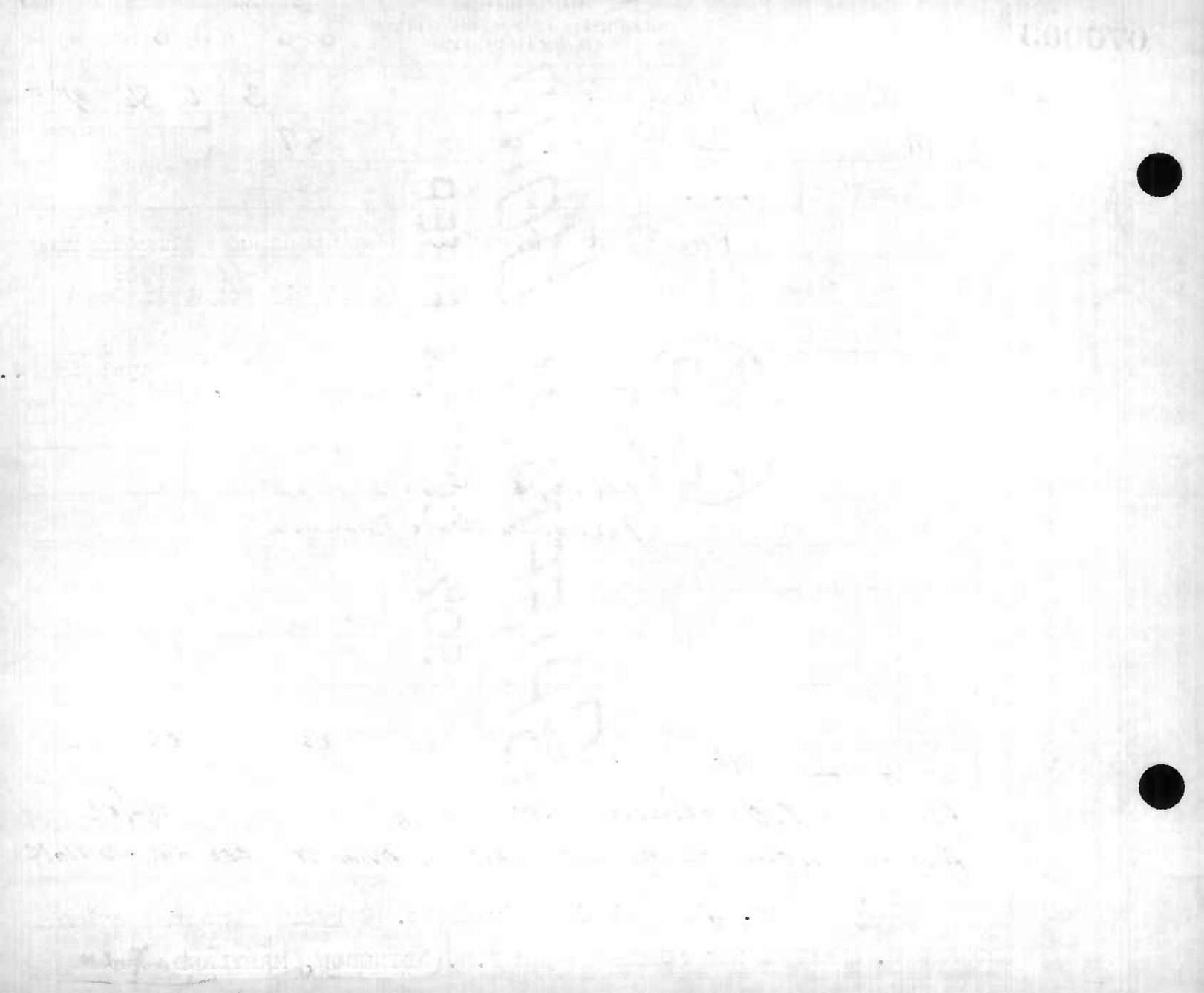
1. DECEASED NAME (TYPE OR PRINT) CLARENCE Woodie, Clarence WOODIE				2d. DATE OF DEATH MONTH DAY YEAR Sept. 10 1898	2e. HOUR 8 10 AM
3. SEX M ale	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 10 1898	6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS	7f. IF UNDER 1 YEAR MONTHS DAYS	7g. IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD		
10. CITY OR TOWN OF DEATH Fallston	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON General			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance	
12b. KIND OF BUSINESS OR INDUSTRY Shoe Manufacturing					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland 13c. COUNTY Harford 13d. CITY OR TOWN Joppa 13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
13f. STREET ADDRESS / ZIP CODE 21085 3001 Old Mountain Road					
14. FATHER'S NAME Loggins	MIDDLE Woodie	15. MOTHER'S MAIDEN NAME FIRST Martha MIDDLE Elizabeth LAST Roupe			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE	17. INFORMANT Louise J. Denton	ADDRESS 3001 Old Mountain Rd. Joppa, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Dehydration DUE TO, OR AS A CONSEQUENCE OF (c) Ischemic Heart Disease					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 315 , 19 86 , to 316 , 19 86 , that (I) (we) last saw the deceased alive on 316 , 19 86 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death					
22b. SIGNATURE Andrew Nowakowski MD	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 3/6/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW NOWAKOWSKI MD	22e. ADDRESS 125 W. MAIN ST. BEL AIR, MD 21014				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE Mar. 8, 1986	23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gds.	23d. LOCATION CITY OR TOWN Bel Air	23e. COUNTY Harford	23f. STATE Maryland
24. FUNERAL DIRECTOR HOWARD K. MCCOMAS III	25a. ADDRESS NAME	25b. DATE REC'D. BY REGISTRAR MAR 7 1986	25c. REGISTRAR'S SIGNATURE Sylvia Davidson Pendleton		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

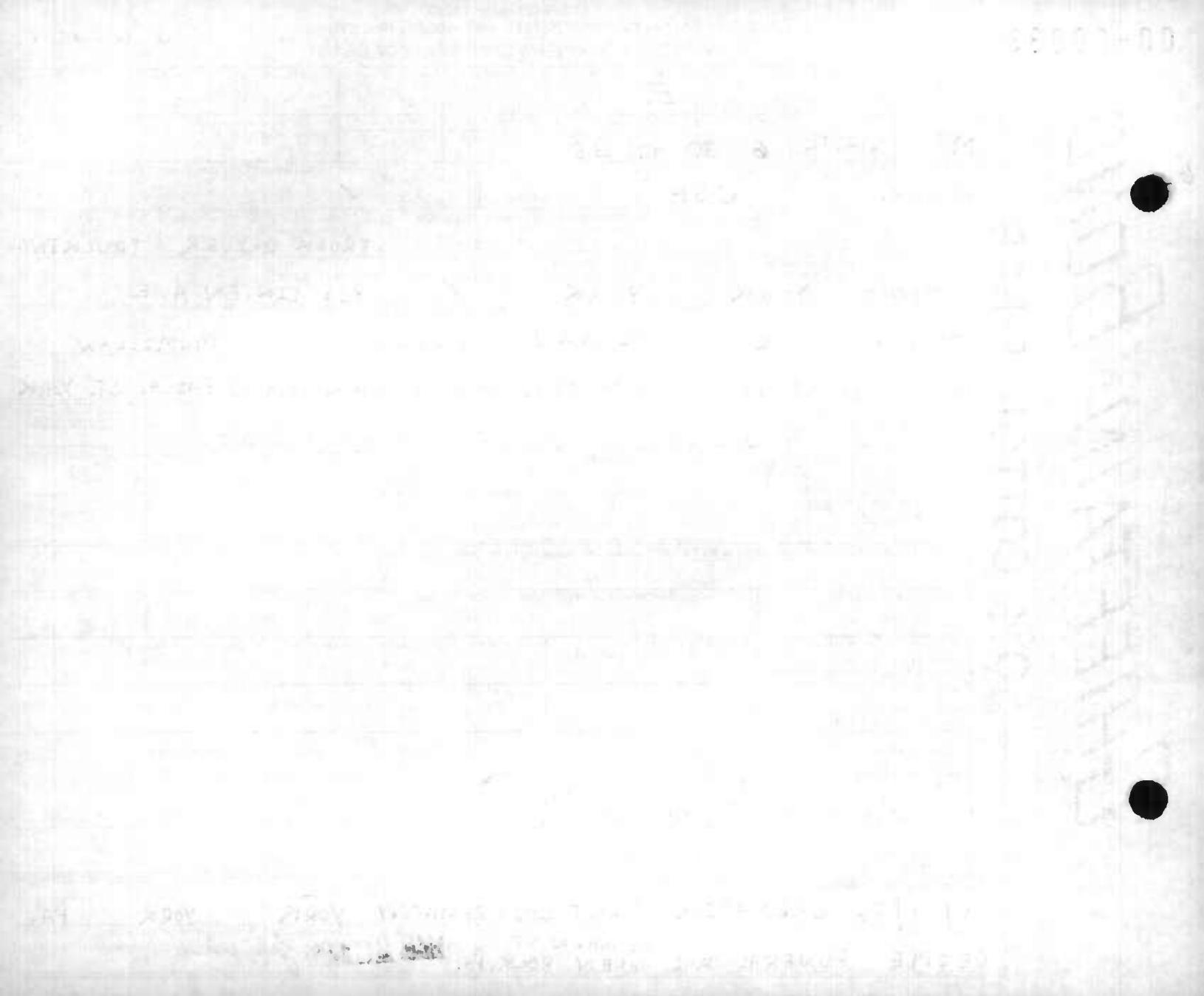
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 08054		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED				MONTH	DAY	YEAR	2b. HOUR	
George			E.	Workman		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3	13	1986	M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	7 IF UNDER 1 YR. MONTHS DAYS	8 IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD				MONTH	DAY	YEAR	2d. HOUR 6:45 a.m.	
M	WHITE	6 30 47	38 yrs.							3	13	1986		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED				9. BALTIMORE CITY OR COUNTY OF DEATH					
PENNA.		USA			<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED				Harford County, MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Havre de Grace			Harford Memorial Hospital					TRUCK DRIVER			TRUCKING			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
PENNA YORK			YORK			YORK				821 LINDEN AVE				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
TONNEY C WORKMAN			ELSIE MCMILLAN											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS						
YES VIET NAM			173-38-7890 JEAN BUTCHER 1319 W. PHILA. ST. YORK											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?						
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE Dennis F. Smyth, M.D. TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER														
DATE SIGNED 3/14/86														
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 111 Penn St. Balto. MD.											
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 111 Penn St. Balto. MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY	STATE		
3/17/86 CREMATION						YORKTOWN CREMATORIAL			YORK		YORK	PA.		
24. FUNERAL DIRECTOR NAME			ADDRESS			53 MAIN ST GLEN ROCK, PA.			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
GEIPLE FUNERAL HOME									MAR 20 1986 Julie L. Anderson					

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1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 0 8 6 5 5
REG. NO.

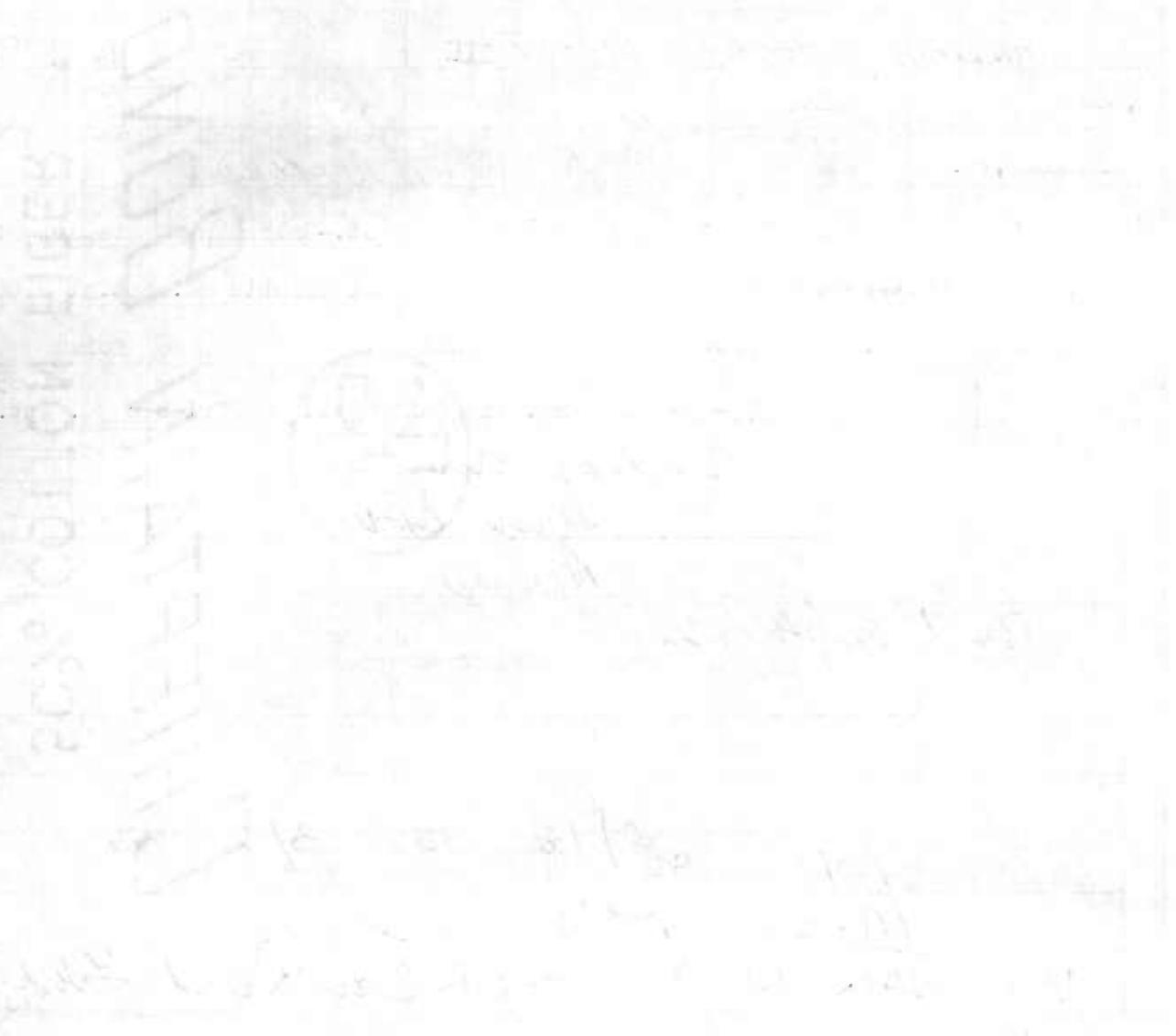
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2d. HOUR	
<u>WILLIAM HENRY WYATT III</u>						<u>3</u>	<u>2</u>	<u>86</u>		<u>6:00 A.M.</u>	
3. SEX: <u>Male</u>		4. RACE: <u>White</u>	5. DATE OF BIRTH MONTH <u>12</u> DAY <u>09</u> YEAR <u>1899</u>			6. AGE [IN YEARS LAST BIRTHDAY] <u>86</u> YRS		IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>		IF UNDER 24 HRS HOURS <u>0</u> MIN. <u>0</u>	
7a. BIRTHPLACE COUNTRY <u>Richmond, Va.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>HARFORD</u>				
10. CITY OR TOWN OF DEATH <u>FALLSTON</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>FALLSTON GENERAL HOSPITAL</u>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Ret.-Salesman</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Stewart Mtrs.</u>				
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Harford</u>		13c. CITY OR TOWN <u>Joppa</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>301 Trimble Rd. Apt. A1 21085</u>			
14. FATHER'S NAME FIRST <u>William</u>		MIDDLE <u>H.</u>	LAST <u>Wyatt</u>	15. MOTHER'S MAIDEN NAME FIRST <u>Minnie</u>		MIDDLE	LAST <u>Neisz</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <u>577-03-8215</u>			17. INFORMANT <u>Mrs. Virginia Wyatt</u>		ADDRESS <u>301 Trimble Rd. Apt. A 1 21085</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>		DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe CAD</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(c) <u>Alcohol</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Cardiomyopathy</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET <u>2118</u>		CITY OR TOWN <u>Baltimore</u>	COUNTY <u>Harford</u>	STATE <u>M.D.</u>		
22a. I certify that (I) (this hospital) attended the deceased from <u>1/18/86</u> to <u>3/2/86</u> , that (I) (we) last saw the deceased alive on <u>1/18/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) leave the body after death.											
22b. SIGNATURE <u>V.S. NAIR M.D.</u>		22c. DEGREE <u>M.D.</u>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <u>10/14/86</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>3-4-86</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Holly Wood Cemetery</u>			23d. LOCATION CITY OR TOWN <u>Richmond</u>		COUNTY <u>Richmond</u>	STATE <u>Virginia</u>	
24. FUNERAL DIRECTOR NAME <u>E.F. Lassahn F.H.</u>		25a. DATE REC'D. BY REGISTRAR <u>11750 Belair Rd. 21087</u>			25b. REGISTRAR'S SIGNATURE <u>MAR 15 1986 John K. Miller</u>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as having an injury or other traumatic event, the medical examiner

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked "D" shows any injury, or other traumatic event, the medical examiner shall be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8608656			
										REG. NO.			
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			7a DATE OF DEATH MONTH DAY YEAR			2b HOUR	
			<i>Loretta E. Ziegfeld</i>						3-12-86			4:28A. M	
3 SEX			4 RACE			5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
<i>Female</i>			<i>White</i>			<i>8-15-1897</i>			<i>88</i>			MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE COUNTRY			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.	
<i>Baltimore, Md.</i>			<i>U.S.A.</i>						<i>Harford County</i>				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY				
<i>Fallston</i>			<i>2409 Claret Drive - 21047</i>			<i>Baby-Sitter</i>			<i>Retired</i>				
13a STATE			13b COUNTY			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS / ZIP CODE				
<i>Md.</i>			<i>Harford</i>			<i>Fallston</i>			<i>2409 Claret Dr. - 21047</i>				
14 FATHER'S NAME FIRST MIDDLE LAST			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
<i>Henry Dankmeyer</i>			<i>Anna</i>										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS				
<i>No</i>			<i>213-42-4198</i>			<i>Mrs. Shirley J. Smith - 2409 Claret Dr. Md. 21047</i>			<i>Fallston, Md.</i>				
18 CAUSE OF DEATH (Enter only one cause per line for 18(a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>CVA, multiples</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>47</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ischemic Heart Disease</i>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <i>Urinary Tract Infection</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE <i>Andrew Nowakowski MD</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED <i>3/12/86</i>				
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>ANDREW NOWAKOWSKI MD</i>			22e ADDRESS <i>125 N. Main St. Bel Air, MD 21014</i>										
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>3-15-86</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Moreland Memorial Park</i>			23d. LOCATION CITY OR TOWN <i>Balto. Md.</i> COUNTY STATE				
24 FUNERAL DIRECTOR NAME <i>John C. Miller Inc-6415 Belair Rd.-21206</i>			ADDRESS			25a. DATE REC'D. BY REGISTRAR <i>MAR 13 1986</i>			25b. REGISTRAR'S SIGNATURE <i>John C. Miller Inc-6415 Belair Rd.-21206</i>				

RECORDED - 1970